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Unity, Understanding and Co-operation

The strains of war have revealed strengths and weaknesses, which were but imperfectly recognized, in organized nursing. This presents the profession with a challenge and an opportunity in the immediate post-war years. Our profession is young and we are yet groping for a pattern of internal organization and of relationships. Much depends on our wisdom and our breadth of vision as we decide the nursing trends of the future.

During the past war years issues of provincial, dominion and international significance assumed greater urgency than ever before. This occurred at a time when each member felt engulfed by her own local responsibilities. Fortunately the Canadian Nurses Association, with the assistance of the federal government grant, was able to expand its activities and has been of very great assistance in meeting the military and civilian responsibilities with which we, as a profession, were confronted.

In the political sphere Dominion-Provincial relationships constitute one of

JEAN I. MASTEN

the most important problems of the day for Canadians. It is very essential that in the smaller sphere of nursing we establish these relationships upon firm foundations. As in the political sphere, each provincial registered nurses association has its own peculiar problems, some of which depend on the political set-up in the particular province, but most assuredly each association should look to the national association for overall guidance and for the most essential co-ordination of all provincial nursing activities. Out of the Dominion-Provincial conferences will doubtless come principles and policies applicable to organizations such as our national and provincial nursing associations.

One of the greatest problems of the Registered Nurses Association of Ontario is to reach every nurse in our large province, gain her interest and support and keep her informed of nursing affairs. The war has shown us that, even in an age providing rapid and reliable air mail facilities, the real decisions were all made during personal conferences. Our immediate intention is to have a member of the provincial office staff go to the ten districts of the province, with time for contacts wider than can be obtained in formal meetings. It will be her aim to discover how the association can best serve its members and to disseminate fuller information than can be imparted in minutes and circulars.

The future holds great possibilities for this most essential of professions. Much change and evolution are inevitable. The nursing profession in Canada will make its best contribution if we preserve the fullest degree of unity, understanding and co-operation in our interprovincial and our national relationships.

JEAN I. MASTEN
President
Registered Nurses Association of Ontario.

Registered Nurses' Identification

When the public see a nurse wearing dull cherry epaulettes with diamond-shaped pieces of green cloth affixed to them, they will know that she is registered as a medical and surgical nurse, and as a midwife. South Africans will soon be able to identify classes of nurses by their epaulettes and "pips".

Hitherto registered nurses have worn a metal badge on the breast which, however, has been optional. The newly-created S. A. Nursing Council has made regulations — approved by the Minister of Welfare and Demobilization, Mr. H. G. Lawrence — making it compulsory for persons registered under the Nursing Act to wear distinguishing badges when on duty.

The following are the colours of the epaulettes to be worn by the various classes: Medical and surgical nurses, dull cherry; male nurses, brown; mental nurses, dark saxe blue; nurses for mental defectives, light saxe blue; fever nurses, yellow; midwives, green. Diamond-shaped pieces of cloth on the epaulettes will indicate whether a nurse is registered in two or more classes, or as a midwife in one or more classes.

A nurse's "pips" will be the Nursing Council's new badge, which will be embroidered in gold-coloured thread near the shoulder edge of the epaulette. The design of the badge is a "Florence Nightingale" lamp over two protea branches, which provide a South African background. It is ringed by the words "S. A. Nursing Council" and "S.A. Verpleegstersraad".

—*The South African Nursing Journal.*

The Adjustments of the Older Nurse

S. R. Laycock

A great deal of attention is now being given to both the physical and the mental hygiene of later life. The study of our older citizens is being carried on vigorously by medical men, psychologists, sociologists, and others. Indeed, in the field of medicine, an entirely new branch of study has grown up — geriatrics, the study of the aged. Psychologists, too, have been studying the problem of the aging of the various human abilities, as well as the extent of the possibilities of learning by older folk. The mental hygienist also has turned his attention to the adjustments of those in later life. Then, too, educators who are interested in adult education and vocational guidance have suddenly become aware of new possibilities for their efforts among those who have advanced to the last two or three decades of life.

The problem of the older nurse is one which gives considerable cause for concern to the leaders of the nursing profession. This problem has two aspects — the economic and the psychological.

Economic Problems of Older Nurses

The economic problem of older nurses is particularly acute in the case of private duty nurses, particularly in regard to provision for their old age. Nurses employed by governments and other public bodies often come under a civil service or other pension scheme. With them, therefore, the spectre of what will happen to them after retirement does not stalk abroad as is the case with private duty nurses. The latter often find it impossible to save sufficient money even to make a beginning of providing for their old age. This fact is apt to cause them to feel not only financially insecure, but also to feel emotionally insecure. "Freedom from Want," it must be remembered, is basic to "Freedom from Fear." Fear caused by the prospect of economic insecurity in the event of illness, accident or retirement is apt to haunt the minds of nurses over forty years of age, and to greatly decrease both their efficiency and their happiness. There would seem to be only two possible solutions for the economic insecurity of nurses. One would be a change in the status of the nursing profession so that, like school teachers, they would be employed by public bodies and come under provincial pension schemes. The other would be a change in the social policy of the nation as a whole whereby *all* elder citizens would, on retirement, receive an adequate pension.

Psychological Problems of the Older Nurse

Nurses are as human as other people. They, too, have the basic psychologic al needs for affection and belonging, independence, achievement, recognition and a sense of personal worth. As they pass the age of forty or forty-five, their concern over the adequate meeting of these needs is apt to be increased.

First of all, nurses, like other people, need to love and be loved, and to feel that they belong to family, friendship and community groups. As they grow older, ties with their own immediate families are apt to weaken. Their parents pass on, and their married brothers and sisters have families and interests of their own. Because of the very nature of the hours at which they work the

social life of many nurses is apt to be interfered with. It is very easy for an older nurse to find that she has no close friends of her own age, especially among married folk. Actually she needs such associations desperately. It is not just a matter of loneliness. Lack of emotional security which often causes delinquency in children is apt to cause symptoms of "old maidishness" among many older nurses. These symptoms may express themselves in bossiness and over-efficiency, gushiness, prudishness or cattiness. When they occur they make a happy adjustment and reasonable efficiency much more difficult.

Secondly, nurses, like other folk, need to feel that they have reasonable freedom in managing their own lives and making their own decisions. Too often, in middle life, nurses come to feel that they are in a treadmill from which they cannot escape. If they are private duty nurses they may feel that they are condemned to the same locality, to the same job and to the same pay for the rest of their lives. Certainly, the fear of becoming economically dependent after their retirement, which was described above, lessens the satisfaction of their present independence. If, on their retirement, they have to go and live with married relatives and be dependent on them, more or less acute unhappiness is nearly bound to result.

In the third place, nurses, like all human beings, have needs for achievement, recognition and self-esteem. They need to obtain joy and satisfaction from the work they do and to feel that they get public recognition for it. They need the approval of their own consciences, and to feel that they are worthwhile persons. If they have chosen their profession wisely and have kept up-to-date professionally, they can find fulfilment for these needs so long as they are able to work. But when they retire, what then? Here the public health nurse may be in an even worse position than the private duty one. She is retired at a definite age no matter how effective and vigorous she may be. She has taken away from her what Dorothy Canfield Fisher calls "the vitamin of WORK". Certainly mental hygienists are agreed that, for mental health, a reasonable satisfaction in the day's work and in the accomplishment of worthwhile life purposes is essential. There are apt to be two kinds of nurses who lack this — the retired nurse, and the nurse who, though not retired, has grown stale on the job and finds her work either distasteful or boring.

Some Suggested Solutions

Assessment of the Assets and Liabilities of the Older Nurse: In order to make wise adjustments, nurses must be aware of the results of psychological studies of the aging of human abilities. It would appear that physical and physiological functions are the first to start declining with age. Then psychological functions, like reaction-time, which involve mental alertness and quickness of response, are apt to decline. These psychological functions are dependent on physiological ones like vision, hearing and muscular response, which are likely to weaken with age. Immediate memory is also apt to decline. It is a common observation that old people are apt to forget recent experiences. Impaired efficiency of immediate memory is, therefore, apt to be one of the weaknesses of later life. The ability to learn new things reaches its maximum in the early twenties and then starts declining slowly. However, this decline can be greatly overrated. Those individuals who continue with new learning during their mature years are apt to be able to continue without too much loss until senility, as such, sets in. It should be remembered that many older people do not learn new things either because of the cumulative effect of poor work habits or because they haven't sufficient

desire or incentive to learn. When it comes to old learning, much of this is quite well retained. The one bright spot in the abilities of older folk is that their judgment and reasoning ability is apt to continue at its peak much longer than their other mental abilities. Miles[1] says: "In the test results for performances, not necessitating quickness in reaction, but depending solely on comprehension, reasoning and judgment; in matters where experience may contribute to the quickness of response; older adults appear most nearly to maintain their characteristic mature scoring level while they continue to maintain mental practice and interest." In this particular field there is apparently a great waste, in our society, in utilizing the experience and judgment of older people. With regard to creative imagination, this is apparently ageless. Individuals may think creatively and make valuable contributions at practically every chronological age level beyond early youth. Some scientists have made their chief contribution after the age of eighty. It would seem that the contributions of older folk to the intelligent solution of problems depend on many other factors than mere age — an eagerness to learn and study, good work and study habits, and the opportunity to make their contribution. How help may be given to nurses so that they will make effective contributions in the latter half of their career will be discussed in the following sections.

The In-Service Education of Nurses: It is vital that the graduate nurse continue to study in a systematic fashion from the day that she leaves the training school. This is for several reasons. First of all, she must during her professional career, compete with her fellows, some of whom, if trained ten or fifteen years later than she, may be more up-to-date. Being up-to-date has *nothing* to do with age as such. Either one is possessed of the most recent knowledge and is proficient in the newest techniques, or one is not. It doesn't matter much whether the nurse who is behind the times is twenty-five or fifty-five years of age, except that the latter is more apt to be suspected of being out-of-date. It is vital that every graduate nurse see to it that, by systematic reading of professional journals and books and by periodic refresher courses, she keeps herself up-to-date. She does not need to fall behind. If she does she may expect to be pushed aside.

In-service professional education is vital from three other standpoints. First of all, it will help to ensure that the nurse continues to find in her profession a sense of achievement, of recognition and of personal worth. These come from efficiency in doing one's job and a keen interest in improving that efficiency. Secondly, as has been pointed out above, the nurse who keeps learning new things will be able to continue learning up to the onset of senility. Thirdly, the nurse who is able to suggest fresh ideas of her own is the one who has been stimulated by constant contact with fresh knowledge gleaned from her reading, as well as from reflection upon both her reading and her experience.

Professional associations of nurses should greatly extend the organization of refresher courses. Perhaps, too, they might consider the advisability of making continuance on the nurses' register contingent upon attendance at refresher courses at stated intervals, say, once in every five years.

Adult Education for Older Nurses: Entirely aside from in-service professional education, all nurses, like all other citizens, should participate in a well-organized adult education program. Such a program should serve two pur-

1. Miles, W. R. R., Psychological Aspects of Aging in "Problems of Aging." Edited by E. V. Coundry, Baltimore, 1942. Williams and Wilkins.

poses. First of all, it should develop community study and discussion of all sorts of community, and national and international problems. The greatest problem of our time is how to live together co-operatively in both smaller and larger communities. Only co-operative study and effort can solve this problem. Secondly, an adult education program should promote the development of individual self-expression through handicrafts, music, art, dramatics, and the enjoyment of good literature. Both of these services of adult education must be available for the older nurse, both before and after retirement. Retired persons need study and discussion clubs, and handicraft, music and art centres quite as much as adolescents need teen-age centres. Adult education is growing rapidly towards fulfilling its legitimate function of helping adults to solve their daily problems and to meet their daily needs. It must do this for the older nurse whether retired or not. Life can be rich and meaningful so long as there is the sharing with others of the solving of personal, community, national and international problems.

Vocational Guidance for Older Nurses: Because vocational guidance is relatively new, those interested in it are apt to confine their activities to teen-agers. In the near future vocational guidance will not stop with the choosing of a job in youth or early adulthood. It will be a service which will continue throughout the life-span. The war has accentuated this need. The requirements of modern warfare are such that many jobs can be done effectively only by those in the twenties, and others by those not older than the thirties. This is true of civilian jobs too. In the future, vocational guidance will be busy shifting and adjusting individuals within their occupations to the jobs they can do best as they grow older. In the past, a person was supposed to work at one job from youth until retiring age in spite of the obvious fact that his physical abilities declined while his experience and knowledge increased. There ought to be a gradual shifting of personnel as they grow older to jobs which mature persons can do better than younger ones. If this were done, it would not be a case of retiring *from* but of retiring *to*. In the case of nurses, many older ones still in service are not suited for the jobs they do. Within the profession there is room for a wide range of skills and abilities. Some of these are possessed in highest degree by older nurses, others by younger nurses. The sensible thing to do would be not to require a nurse of sixty to do what she could have done well at thirty. Rather she should be shifted, without loss of prestige, to a job which, at sixty, she can do much better than at thirty because of her experience and her continued growth. It is, of course, her job to see that she has grown in knowledge and experience through the years so that, at sixty, she has resources which she didn't have at thirty. There are many contributions to society which those over sixty can make when we think in terms of vocational guidance as a life-long process and not merely a matter of picking a job for an eighteen-year-old with the assumption that it is equally suitable for her at twenty and at sixty.

Counselling Service for Older Nurses: In the United States there has been a rapid growth in old-age counselling centres where the older citizens are helped to solve their problems and to make wise adjustments. In the case of nurses, this service must be performed by someone connected with the provincial offices of the nurses' associations. At the least it should be made possible by such associations.

Heading Off Maladjustments: The time to head off the maladjustments of later life is in early life — the earlier the better. It would seem that counselling services should be provided for

younger nurses so that they may look ahead and plan, not only for happiness and efficiency at the moment, but for a full life-time of such happiness and efficiency.

Human life is full of problems. Down through the ages man has set himself to the solution of these problems. One after another they have yielded to intelligence, persistently applied. The experience of the race should give hope that every problem of human living will, in the long run (and often in the short run), be solved by intelligent and co-operative effort, the problems of the older nurse being no exception.

Tick and Insect Borne Diseases

F. A. HUMPHREYS, D.V.Sc.

In Canada and the United States a number of diseases are transmitted by the Rocky Mountain wood tick (*Dermacentor andersonii*) and the American dog tick (*Dermacentor variabilis*), both of which are widely distributed. The so-called wood tick is not found on trees, as many people think, but on grass, small brush, and weeds native to open spaces. Ticks always tend to crawl upward. Hence protective clothing, such as high boots, leggings or puttees, should be worn in tick-infested areas. The undiscovered tick is thus prevented from attaching until it reaches the neck or head where it is more likely to be seen or felt. In attaching, a tick may cause a slight sting, but usually it attaches without causing any noticeable irritation whatever because the hypostome seems to gently anesthetize the skin as it penetrates. Occasionally the site of attachment becomes an ulcer, which is extremely slow in healing. When a tick is found attached it is best to remove it immediately for each added moment increases the danger of spotted fever being transmitted, although ticks rarely transmit infection until they have fed from four to six hours. The easiest and quickest method of removing them is to gently pull the tick off with the fingers. When sterile instruments are at hand ticks of any species may be removed easily by pulling the tick gently so as to make a tent of the skin surrounding the site of attachment and then slipping the point of a hypodermic or scalpel under the mouth parts. The instrument is then raised, thus removing the mouth parts with a minimum of tissue. Iodine, a silver nitrate pencil, or some other antiseptic should be applied to the site. There is no proven substance which can be placed either on the clothing or on the body to prevent tick attachment.

Tick paralysis is as yet something of a mystery. It not infrequently occurs about the fifth or sixth day following the attachment of an undiscovered female tick, usually when the tick is in a state of at least semi-engorgement. It is not often seen in children and young animals, and nearly always disappears promptly when the offending tick is removed, provided extremis has not been reached.

Infected ticks are extremely dangerous visitors, but fortunately the percentage that are infected is small. In the United States it is from less than 1 per cent up to 4 or 5 per cent. In Canada so far it is much less than that.

Areas of infection seem scattered. Part of the work of the national health laboratories is in the nature of surveys to determine where areas of infection occur.

Two of the most widely known tick and insect borne diseases are Rocky Mountain spotted fever and typhus fever. They are caused by *Rickettsiae*, so called in honour of Dr. Howard Taylor Ricketts, who was the first, in 1906, to prove that spotted fever is carried by ticks. Rickettsiae may be considered as midway between bacteria and viruses. They can readily be seen when properly stained and are not filterable, but like the viruses, cannot be grown on lifeless media. Although spotted fever has been diagnosed in Western Canada a number of times in recent years, the causative rickettsia was isolated for the first time in this country only last year when it was recovered from a fatal case of the disease in a man in Southern Alberta.

Rocky Mountain spotted fever is not confined to the mountainous regions as originally thought, but is now known to have a wide distribution extending into the Eastern United States. A few cases have been reported in British Columbia, and several have occurred in Alberta. The incubation period is from two to fourteen days. There may be a prodromal period of from two to fourteen days or longer, characterized by loss of appetite, irritability and malaise. The symptoms most often complained of at the onset are frontal and occipital headache, intense aching in the lumbar region and marked malaise. The typical rash is coloured from pale to bright rose and is commonly macular. It extends rapidly to all parts of the body including the palms of the hands, the soles of the feet and the mucous membrane of the mouth and throat. The febrile period is from two to three weeks, but may be longer or shorter. The maximum temperature may not be greater than 103°F. In recovery the temperature falls by lysis and reaches normal by the end of the third week. In fatal attacks there is occasionally terminal hyperpyrexia, the temperature reaching as high as 108°F. The lungs are usually not involved, but a slight hacking, non-productive, bronchial cough is typical. Convalescence is slow, and complete recovery may require from one to several months, sometimes a year or even longer. This may be true of even relatively mild infections. Careful nursing is important. The patient should be kept at rest, avoiding overtreatment. Penicillin may be of value but the sulfa drugs are useless.

In diagnosis, Rocky Mountain spotted fever is sometimes confused with typhoid fever measles, scarlet fever, smallpox, post-measles, encephalitis, secondary syphilis, Colorado tick fever, and endemic typhus fever.

Typhus fever was long confused with typhoid and only in the last hundred years has it been possible to differentiate between them. The cause of typhoid was discovered in 1880, while the cause of typhus was not found until 1916. There are two types of typhus: (1) Murine or endemic which is rat-borne and transmitted by fleas; (2) European or epidemic which for centuries was common in the Old World and is louse-borne. It was known as gaol fever or ship fever. The word "typhus" means stupor, and this term was probably applied because of the extreme prostration which accompanies the infection.

In 1659 typhus fever was epidemic in Canada for the first time. It was brought to Quebec from France and spread rapidly among the inhabitants causing many deaths. It has always been a serious problem in armies. It played havoc with Napoleon's troops in their retreat from Moscow in 1812. In this famous rout, cold, famine and several other diseases played their parts, but typhus seems to have been the greatest factor in the defeat. It was also a ter-

rible scourge in the French and British armies, especially among the French armies in the Crimean War, 1854-1856, in which Florence Nightingale played such an important role.

Plague is one of the world's oldest diseases. The outbreaks of epidemic disease mentioned in the Bible were probably this infection, but the greatest outbreaks of it were those that occurred in the fifteenth, sixteenth and seventeenth centuries when it became known as the Black Death. In Europe about twenty-five million people perished from it, and in Great Britain alone one half to two thirds of the population are said to have died of it. It is usually spoken of as bubonic plague because of its tendency to form buboes, a bubo being a swollen and extremely painful lymphatic gland. The really dangerous form, though, is the pneumonic type which is seen when the infection colonizes in the lungs, as it often does. A bronchopneumonia then develops and the infected person, through coughing, is liable to infect every one who comes near.

Plague infection is, of course, carried by rats, although other rodents such as mice, ground squirrels, and ground hogs are susceptible. It is transmitted by fleas, and is continually being looked for in rats which may be introduced along the Pacific Coast from ships. Two years ago and again this year it was found in rats and mice in Tacoma. Some spectacular outbreaks have occurred in California. It first appeared there in 1900. Up to 1925, 405 cases occurred with 257 deaths. Of these, 46 were the pneumonic type, all but 3 of which died. Since then several more cases have occurred. The infection is picked up nearly every year in ground squirrels somewhere in the Western States.

As an example of the infectivity of plague in Los Angeles in 1924, a Mexican woman died after four days of illness — no diagnosis. Three days later the woman's husband and a practical nurse who had nursed her were taken ill. Both died. An autopsy was carried out on the husband and the cause of death given as double pneumonia. A week later eighteen contacts had been admitted to hospital. All developed pneumonia and all died after an average illness of four days. All were friends and relatives of the original patient.

Tularemia is a plague-like disease of rabbits, ground squirrels, and other rodents. It is transmitted by ticks and biting flies. It is extremely infectious and causes a variety of symptoms in man, such as an ulcer at point of infection, swollen, painful glands, and pneumonia. The mortality is not high, possibly 5 to 10 per cent, but the illness may be lingering, varying from a few weeks to two years. The infection is widely distributed. It has been found in the Kootenays of British Columbia and at several points in Alberta and Saskatchewan.

Relapsing fever is caused by a spirochete and is transmitted by certain ticks and by lice. The greatest epidemics of it occur in North Africa and India, though numerous cases have occurred in the United States, and several have been reported in British Columbia. Six cases occurred at Trail in 1933. As the name indicates, it causes bouts of fever which tend to subside after a few days, but later return. Usually four or five relapses occur.

Preview

Are you having problems with the much used hospital equipment? W. J. Coleman has given us some very useful pointers on the care, maintenance and conservation of a wide variety of equipment and materials which should help us to keep things going until the day when new supplies are once more available.

Interpretation of Medical Social Work

H. Aline Paice

In order to show something of the development of this branch of hospital care it is necessary to understand how it originated and what special emphasis may be noted in its growth. As all nurses know, the spirit of service to the sick is not new.

Throughout the history of the Christian church, the spiritual welfare of the sick has always claimed the attention of the clergy. In England, as early as 1791, the London Hospital organized a group of volunteers to follow patients into their own homes for the purpose of providing suitable aftercare. There are some fundamental differences, however, between the early concept of social service and that of the present day. Formerly, neither the clergy nor the friendly visitor co-operated closely and constantly with the doctor, nurse or community resources outside the hospital. It has remained for the hospital social worker of the present day to define and develop the function of the unofficial visitor.

The first effort to establish this form of hospital service was made by Sir Charles Locke in 1885. After many years of careful study of hospital systems he found there existed an appalling waste of skilled attention, time and material lavished on the patient, due to the absence of a connecting link between the hospital and the world outside. He made a report to a Select Committee of the House of Lords on his findings, which resulted in the appointment of the first Lady Almoner (Miss Mary Stewart) in the Royal Free Hospital, London, in 1895. Miss Stewart was a trained worker who had had considerable experience with the Charity Organization Society in London. She was the forerunner of the vast scheme of hospital social service which, in various guises, has gradually developed all over the world.

The development in North America is due in one case to a doctor and in the other to a nurse. It was Sir William Osler who between 1898-1900 started the idea. Dr. Osler taught the medical students the social as well as the medical aspects of tuberculosis. He made it possible for two third-year medical students to follow "the consumptive out-patients to their homes to investigate the conditions under which they lived and to see that the proper hygienic directions given in the hospital were actually carried out".[1] Somewhat later, Miss Mary Wadley, superintendent of nurses, Bellevue Hospital, N.Y., required the nurses to visit in the homes of the patients to secure information pertinent to a fuller understanding of the conditions under which they lived. In this way, she helped them better to appreciate the connection between patients' illnesses and the problems of their daily lives. It was in recognition of this need that Dr. Richard C. Cabot, in 1905, started medical social work by securing permission from the Massachussetts General Hospital to actually bring a social worker into the hospital, to work under his direction with special patients whom he was treating in the ward and clinic. From this small beginning, the practice spread rapidly until today well over five hundred hospitals in the United States and Canada employ some 2,063 medical social workers. (1943 statistics). "As the movement grew, it was natural that various emphases developed. Administrators saw in this new personnel a resource for many other uses, such as collecting bills, preventing abuse of free facilities and doing many odd jobs for which no one else seemed

available".[2] Because of this chaotic situation, and because those workers whose experience had continued more closely in line with the original concept were concerned with assuring a thoughtful and sound development for this emerging profession, in 1918, with Dr. Cabot's encouragement, they organized into a professional group known as the American Association of Hospital Social Workers. Within a few years, district sections were formed and one of the early ones was the Eastern Canada District, which started in 1923 with headquarters in Montreal.

As early as 1920, studies were undertaken to establish what might be considered the appropriate function of the hospital social worker. A committee of the American Hospital Association, which included members of the hospital social work organization, made the first of these studies and, in succeeding years, three others have been made by the professional association of medical social workers. The following points are today accepted as defining the function of the medical social workers:

(a) Practice of medical social case work: Inquiry into the social situation of hospital patients and the reporting of the findings to the responsible physician; determining, in collaboration with the physician, the factors in the social situation pertinent to the patient's health and stating these as medical social problems or diagnoses; setting up, in collaboration with the physician, a possible goal for the patient to aim for; distinguishing the role the social worker is to play in the plan for helping patient achieve the goal; executing the social worker's part in the plan.[3]

In addition to this, the Statement of Standards, accepted by the American Association of Medical Social Workers in May, 1936, and revised in May, 1940 lists the following additional functions:

(b) Development of the medical social program within the medical institution.

(c) Participation in the development of social and health programs in the community.

(d) Participation in the educational program for professional personnel.

(e) Medical social research.

Medical social casework begins its function when the clinician desires the worker's assistance and when she is released from pressure of miscellaneous tasks that divert her from giving a high quality of social casework service. Social Service Departments are often asked to participate in the teaching of student nurses when the school of nursing wishes to incorporate some aspects of medical social work in their curriculum and if there is adequate social service staff, a worker is delegated to the teaching department to work out a suitable plan for student nurses. In this article we shall discuss only the main topic of the medical social worker's function as a member of the "medical team" made up of the doctor, nurse and social worker, each bringing his or her unique contribution to the care of the patient in the ward or the clinic of the hospital.

Function

The function of medical social work is to help sick people with problems arising from their illness or medical care. Its most characteristic feature is the individualization of the patient, his particular needs, and his reactions to his illness, treatment, and his personal relationships. All of these factors must be properly understood by the social worker to enable her to gain sufficient insight to meet the patient's needs. Her best sources of information are the physician and nurse. Mutual understanding of each other's function and goal is vital to success.

As the physician sees his patient in the ward or clinic, he is able to see him in only a comparatively isolated way. The patient, for the time being, is sep-

arated physically from his natural setting. He may be confused by the number of people who serve him, the highly technical procedures, the presence of other sick people, the separation from his home and family, the difficulties of carrying out the doctor's recommendations, lack of understanding of his condition, fear of the future. The patient with a severe heart condition, faced with the necessity of a complete change of work, or even cessation of it, when he has a family dependent upon him, has a serious adjustment to make. His response to these problems, and his ability to get and use help in meeting them at an early point, often affects the way he responds to medical care. The patient with gastric ulcer must often have help over a long period to adapt himself to a diet sometimes difficult to get, or at variance with his habits of eating, to say nothing of the necessity of living calmly in the face of worries or strains. The surgical patient who has suffered the loss of an arm or leg needs understanding case treatment, if he is to go forward in life as an adequate person. One could enumerate many such illustrations but, through them all, runs the need for the skilled case work relationship which can help build strength for self-direction and readjustment, and bring forward those resources within the patient, in his family, in society, which the patient can use effectively while medical treatment proceeds and as he gradually becomes adjusted to his limitations.

Sometimes the medical social worker needs only a short contact with the patient to bring about a release from tension, fear and insecurity. While the patient, suddenly faced with a diagnosis such as tuberculosis, syphilis, or a serious operation, may need only one, two or three interviews with the medical social case worker in order to see his way clearly, to rally his resources, and to go forward, he may also need much longer and more comprehensive treatment. In addition to her understanding of the social implications of the patient's disease, and her case work skill in interviewing, there is an added value in her immediate availability so that the doctor or nurse can bring her in at the crucial point.

There is an increasing tendency to use the skills of the medical social worker at the admitting desk and in the social review of all cases coming to certain clinics or wards. The value of having the patient meet the trained medical social case worker at his first contact with the clinic or hospital is that, not only his medical and social needs are considered together and integrated in the decision to admit him to free, part-pay, or full-pay services, but also that any medical social treatment which he may need in his later care is started at that point. The probable expense of his own medical care, the relation of his particular illness to his later ability to earn, to the other expenses of his family, and to his standard of living, are all balanced in the light of the policies of the hospital and its particular facilities for medical care. The case work approach, so important if there is to be lack of tension, readiness to follow advice, and the best possible outcome of his medical treatment, if begun at the admitting desk may often preclude later long and expensive readjustments, or even ultimate failure to help him adequately. This type of service is of value only when there is an adequate staff available for the full treatment of which these services may be simply the first step — an important one — but effective only if it can be carried through in indicated instances. As Dr. Cabot said, "Quick judgment necessary in these services calls for the best trained case workers available at these points, and one would warn against the establishment of social admitting, or 100 per cent social review, until adequately trained and experienced personnel is available for both types of service."

Before interviewing the patient, the worker must have a complete picture, both from the medical record and from the doctor-in-charge, and a knowledge of any previous experience which the patient may have had with other social agencies in the community, in order to be as much use as possible to him. It is by the process of interviewing that a helpful relationship is built up between worker and patient so that he can express his problems and try to solve them.

The following case illustrations will give an idea of our work with the patients:

Case 1. The patient, a single Ukrainian girl, age 30, with rheumatic heart disease with mitral stenosis and aortic insufficiency and with chronic passive congestion of the lungs, was referred to the medical social worker for convalescent care by the resident doctor. The patient had scarlet fever at the age of 17 and was hospitalized for rheumatic fever twice in the next two years. She is a pretty, intelligent, very sensitive girl. She is demanding and sulky when she feels people do not like her. Her mother died when she was born and she was placed with foster parents. They made her feel unwanted and unloved. At the age of 12 her foster mother died and she tried living with her real father. She was very unhappy there since he had remarried and had several children. The patient went to work as a maid at 13 years of age and has supported herself ever since. She has not seen her father since she left home.

The patient needs a lot of understanding and attention, more than it is possible for most people or institutions to give her. We have tried to give her this with the aim of helping her obtain medical care and to accept the limitations illness creates for living a full and normal life. For a year our activity has consisted of helping in every area arising from her medical social needs. She was referred to a family welfare agency for financial relief. The patient has made very uneven progress and is at present in a hospital for chronic and incurable diseases because no other placement is available at this time. She has found it very difficult to adjust to this hospital since the majority of patients are aged and there is a high death rate. We have continued to visit and write her since there is no social service department in her present hospital. The patient depends on us to help her and knows that our interest will continue until she is ready to carry on alone.

Case 2. A fall outside the house where she worked as a personal maid created a problem for Miss M, a 58-year-old single woman who had come to Canada about fifteen years ago direct from Paris. On admission to hospital she was found to have a fracture of the lower right tibia. A bone plating was done and cast applied above the knee. Miss M. was referred to the medical social worker by the head nurse on the day of admission because she was upset about the accident and would have to make plans for convalescence and ultimately a readjustment to a different type of work. She has an attractive manner and a sensitive face; she looks younger than her years. She speaks English quickly and fluently but with a marked French accent. During the first interview she cried often, repeatedly stating that she did not seem able to control herself and could not think clearly about what she should do. She had a real fear that she would never be able to walk again; her physical disability made her feel insecure because she had to depend upon abilities other than her own for direction. She explained that she was the only child of deaf parents, therefore she had early learned to think for herself and find answers to her own questions. Because she was born late in her mother's life, she thought she had not the same physical stamina to counteract the effects of such an accident. Although she was trained as a seamstress in Paris, in order to save money for her future in Canada she had also worked as a personal maid. She foresaw the savings, with which she had hoped to purchase a boarding house, being used up in payment for treatment and a long convalescence. Fortunately she had a room in the city which she had kept for her use even while she worked at private residences. This she can turn to when she is able to walk on crutches.

Medical social case treatment, during the first four interviews, was directed towards providing a release from these fears, helping her to regain more of her former emotional stability. The worker discussed the fact that she, like many people, was hypersensitive and easily overcome by anything

related to herself. She was given reassurance that because she was able to plan for herself before the accident, she would in time be able to do so again. In addition, she needed a careful explanation by the doctor about her fracture and the exact treatment she would require before she could use her leg again. She was then ready to use the convalescent hospital available where, over an eight-week period, she was helped to walk and learned to look after herself. This lessened her feeling of helplessness and made her more prepared to look after herself in her own room.

While this patient has not yet the use of her leg, from the time of her admission to the convalescent hospital she has made her own plans, using the medical social worker as a sounding board. Her confidence in the medical treatment, continued careful interpretation from the doctor, and her increasing adjustment to her disability, indicate that medical social case treatment can be discontinued shortly.

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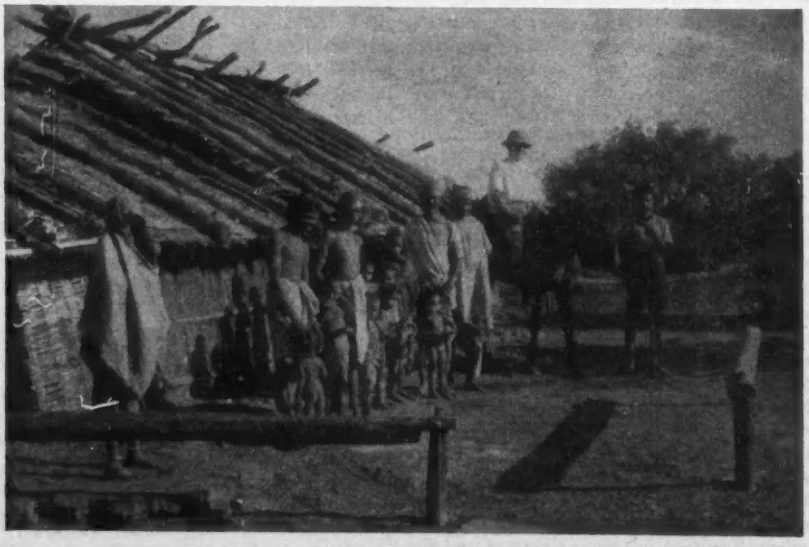
From One Post-war Period to Another in Canada and India

EDITH BUCHANAN

As a child, I had ridden out on horseback with my father on his rounds, to those little homes in scattered clearings of the jungles of the Vindya mountains



Dr. Buchanan visited the people in their homes.

in Central India. I had watched him pull out arrows deeply imbedded in flesh and bone. I had watched him stitch up ugly gashes, seen him with pneumonia patients, seen him vaccinating the whole community, seen him dosing all the school children and trying to get down the size of those chronically enlarged spleens. I had gone with mother (who also was a doctor) in the evening when she visited sick babies and mothers; seen her work to supplement those fever and dysentery diets; and heard her teaching relatives how to carry on till the next visit. I remember her working all night over people with snake bite, working over children with convulsions, going out at all hours to people who were sick, poring over her medical books looking up the treatments — and I remember her scrubbing me with soap and water and admonitions until I was almost raw, after I had picked up a medicine bottle returned from a cholera house. Yes, I thought I remembered India, when I went back at the beginning of 1936 — but what a lot I had forgotten! Even the last word of the language!

I needed a job so I went up at the beginning of the hot weather, after a short visit in the countryside of my childhood, to a mission hospital in the Punjab that needed a nurse. It was dirty and hot on the train. Fifteen minutes after a hopeful wiping of the seats, a pall of dust and sand settled down that you could write your name in, your throat dried up, and earth gritted between your teeth.

When I arrived I was shown into a bare bedroom and discovered that I needed to supply sheets, towels, curtains, pillow and mattress, everything of my own except the actual sticks of wooden furniture and the big oval zinc wash tubs, cleanliness-is-next-to-Godliness arrangement, with a kerosene oil tin of hot water beside it. So I sent away for linen by mail, hauled out all the paraphenalia of apron and uniform for the morning, and slept very comfortably on

Primitive hunting weapons.

the tape bed with a sheet over it (it's the cool way to sleep in hot weather).

The next day we started with a breakfast that included chapatties (unleavened bread) and went right over, with that as a sort of leaden anchor amidriff, to the hospital. There were sometimes three or four people who spoke English and sometimes none in that hospital. Well, if you *have* to learn a language it soon comes to you, and that summer between dust storms and flies, prickly heat, dysentery and sore eyes, I learned quite a lot, and saw a lot of life—people rich and poor, in gorgeous raiment or in rags — but always colourful, a never-ending pageant of people. There were long moonlight nights, too, when we slept out of doors; and others, longer, and less lovely, when we fled indoors before a rising dust storm and tossed in dust-choked heat as the lightning flashed and the eucalyptus trees swirled and lashed in the earthy air, like furious breakers in a gale. A long siege as a patient was the climax of the summer, ending up in a big Calcutta hospital. It overlooked a main

thoroughfare of the city, where herds of cattle wandered all through the night and into the early hours of the morning, and sheeted figures, like the dead, slept out on cots in the street for air. Fans whirred all night over our beds, and still our foreheads were damp with perspiration.

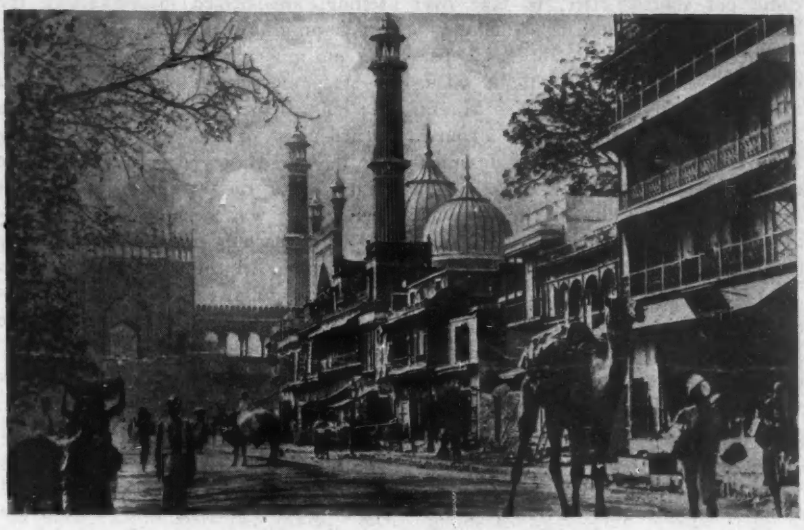
And that may be the colour of the whole Indian experience for a lot of people who go to India in the army or on business, and perhaps never get a chance to like India because of their own physiological difficulties in the first year or two before immunity is built up and adjustment made. So don't be surprised if some of our army men and women don't like it. Many of them have had a bad time physically with malaria and dysentery. Some of them, however, may get a chance as I did to see that same Northern Punjab in the cold weather, which feels colder than England and everybody knows how much colder England feels than Canada! (I certainly never wore winter woollies in Canada!) Anyway, the Punjab is a land of roses in the winter and of all the flowers you care to grow. The vast wheat fields stretch to the horizon, watered by a network of canals from the five rivers that name the province. Far across the green plain, against a clear blue sky at sunset, may be seen the rosy snow-covered mountains — the mother-of-pearl fairyland of Kashmere. And by the roadside long caravans of oxcarts camp for the night, smoke winds up from fires of cow-dung cake, oxen chew their cud while bells tinkle drowsily and camels settle down lugubriously and disgustedly for the night.

I had taken my instructor's certificate at McGill under the inspiration of Miss Lindeburgh, and had taught at the Royal Victoria Hospital for three years before I went out, so I was looking for a job in nursing education rather than supervision and administration. In November, 1937, I went to the Lady Hardinge Medical College Hospital in Delhi to get some experience in different fields and with a view to going into my own particular branch of work.

Delhi is the Ottawa or Washington of India, except that it stretches far back through a long line of royal capitals to an ancient and almost prehistoric past. It is built at the crossing point of the old caravan routes going from East to West and from North to South. It has in it the "star of India" of the future, blended with all the colour of the past — all the romance of "The Golden Road to Samarkand" and the "Twenty Caliphs of Bagdad". Fine modern buildings and some of the noblest architecture of the great Moghul period are to be found in and near Delhi. The famous Taj Mahal is less than one hundred miles away; Fathepur Sikri, also the rose-coloured sleeping city of the great Emperor Akbar (contemporary of Queen Elizabeth), and his glistening tomb at Sikandra, open in high marble-screened solitude to sun and sky.

You may be very miserable in Delhi if your life is still all prickly heat and dysentery, for it has six very hot dusty summer months. If, however, you have accomplished some physiological adjustment, got some immunity, a healthy routine, and a zest for life again, then it is a place to delight mind and fancy alike. For me it was fortunate in progressive professional interest as well.

At the Lady Hardinge, Dr. Ruth Young was medical superintendent of the Hospital and principal of the Medical College. She had done much in health and preventive work for India, and had travelled widely under the Rockefeller Foundation, visiting Canada, the United States and many other countries. (She has since been called out to advise on health matters in Abyssinia.) Miss Winter, D.N. (London University), was the superintendent of nurses. She also had had wide experience in India, and in addition had been for five years on the staff of the College of Nursing in London. The Lady Hardinge



Street scene in Delhi.

Medical College, School of Nursing and School of Pharmacy all are organized to give professional training to Indian women, and the hospital similarly is designed to serve Indian women and children. I couldn't have found a more interesting institution in which to work and learn. Miss Winter "pushed" me about from experience to experience—much as Miss Hersey had done in my own hospital—to get the wider background and knowledge which helps so much in teaching. I started as "hospital steward" with the function of ordering, keeping track of, and distributing all linen supplies and managing the sewing department (five cross-legged Mohammedan tailors on a verandah). I also had direct charge of the kitchens. The hospital was being reorganized to include better and more varied Indian diets. I had the fun of burning the midnight oil night after night working out and balancing Indian diets for vegetarian and non-vegetarian patients; working out costs; presenting the new diets to the hospital committee for approval. Non-vegetarian kitchens were introduced in addition to the vegetarian. Five high caste Hindu women cooked on the vegetarian side, sitting on the floor over fires of coals, making some six hundred chapatties a day in addition to the other dishes. I might neither touch anything on that side, nor so much as step inside the door, for fear of polluting the food. Two Mohammedan women cooked on the other side. Only one woman out of the seven could read and write a little, so that each kitchen had its own hot food carriers for every ward marked in colour to distinguish them. Each kitchen had a slate ruled in sections with rows of solid circles to show the numbers in each ward on the various diets. Incidentally, I found these same almost illiterate women interested, open-minded and eager to do their part towards improving hospital diets, even when it entailed more work and worry. So the next time you find your reforms blocked, and people unwilling to accept change, you had better come and borrow keen bright-eyed Sobadra, the high caste head cook woman—to help you. The post of "diet sister" was given me to pave the way for a trained nurse dietitian from the London Hospital, who

came out shortly after, to take over and build up the whole department.

Since I could not qualify as a permanent "senior sister" without taking midwifery I then went down to Madras as a student nurse again to take a course. I have always been exceedingly interested to know what it is like to be a student nurse in India, and to see what a big hospital is like from below and inside as it were.

Madras is rather more different from the Punjab than Egypt from France or Italy. Culture, religion, appearance of its people, speech, language derivations — all are different. Again, I had to pick up as much as I could of the language for it was routine to be left alone with a ward full of patients on evening duties. Sometimes there would be a Mohammedan woman speaking a corrupt form of the Urdu or Hindustani of the North, and I could use her to help me to explain things. Sometimes there would be no one who spoke either Hindustani or English and then came the discovery of what wonderful dramatic talent there is in all of us. It's amazing how much you can explain by smile and gesture if you have to.

Family illness called me away from Madras, but I later finished up my midwifery at Delhi and did a junior sister's work in a gynaecological ward while doing it, which gave me another useful close experience with patients, student nurses and doctors. As soon as my examinations were over I took over the teaching in the school of nursing, following a sister tutor from St. Thomas's Hospital, London, with her instructor's certificate from King's College, who had just married. I started right in with a preliminary training school group. Miss Winter helped me in adjusting to the classes of student nurses, drawn from all over India, of such different language, religious and cultural groups. She helped me to adjust to the very different system of nursing also, based on the English system. She herself taught, did a lot of testing, and helped in organizing the whole programme. She was always helping me in practical ways—for example —by noting suitable patients for clinical teaching as she made her rounds. Since I had most of the organized teaching for the two classes in each of the three years (with the exception of doctor's lectures) it was a sound way of making ward teaching practicable in a heavy programme. In the wards, sisters who were able followed the English tradition and did a lot of informal bedside teaching. Others did less.

Those years of work under Miss Winter were a great help and inspiration. Much was being done in an organized scientific way to improve the hospital, to improve nursing care and, basic to it all, to improve nursing education. Gradually a waiting list of student nurse applicants had grown, and the school was able to choose those who were matriculants, those who had one or two years of university work, and even a Bachelor's Degree. More than that, as in other improved schools, students of different cultural groups were seeking admission, and from all over India. They came, and will come, for two definite reasons — first, for the clear organized learning opportunity provided; secondly, for the properly supervised residential life with a real care for diet and health and some guidance in that first experience of freedom after the very strict seclusion of boarding school or Indian home. While some 80 per cent of India's nurses are Indian Christian or Anglo-Indian women, including many daughters of teachers, ministers, doctors, etc., there are also students in smaller numbers (some 20 per cent) from all the other religious and cultural groups.[1] I have had students who were Rajputs, Sikhs, Brahmins, etc. (occasional ones were widows). I have had Mo-

1. Journal of the Christian Medical Association of India, Burma and Ceylon, Sept. 1944, p. 197.

hammedans and Parsees. (The Parsees are a small highly intellectual group, very influential in hospital work in Bombay; Miss Adranvalla, a Parsee nurse, is nursing superintendent of the great J. J. group of hospitals in that city). Most of the students from these varied religious and cultural groups come from families where a member is a doctor, or is in the army or other service, in law or in one of the professions. One was the daughter of a Rai Bahadur (equivalent of "Sir"), another of a Commissioner, another of a Post-Master General, another of a Master of one of the most select boys' schools in India, etc. They come from all over India and from outside India as well. Many know four or five languages, including English, and learn Urdu, the language of their Delhi patients, during their training. We used Urdu a good deal in informal discussion and explanation. Visual aids, the laboratory method demonstration and return demonstration, assignment, discussion and question — student participation of every sort and close contact with the student are obviously even more important than in teaching a single-language group. There is just the same quick response and lighting of the eye that you see in any keen intelligent group of young women, who are getting satisfaction in preparing themselves scientifically for a chosen profession. A joke and laughter lighten teaching situations in any group and perhaps even more if the weather is hot and the "loo" is blowing (the desert wind). They all lived in the same nurses' home, ate in the same dining-room — although some ate vegetarian and others non-vegetarian dishes. They all did the same things on the wards, including the giving of bedpans. Given any sort of a lead from the head nurse (or sister) in doing that sort of thing herself, they were only too quick to play their full parts in the complete care of the patient. Some indeed were all the more conscientious to do things that were difficult to them, just because they had made up their minds so thoroughly to undertake the whole of nursing.

(*Editor's Note*: This fascinating story of the joys and tribulations of nursing in India will be concluded in next month's issue. In it, Miss Buchanan's sterling analysis of the future possibilities for nursing points the way to a new era. If you are interested in work in an exotic foreign land, do not miss the final instalment.)

The Story of Joey

INEZ NESSET

Joey and Johnny, twins, two months, four days premature, were born December 14, 1944, at the Paddockwood Red Cross Outpost. Johnny, hydrocephalic, two pounds, nine ounces in weight, died four hours after birth. Blonde, twelve-inch Joey, minus eyebrows, lashes, toe and fingernails, two pounds, one-and-a-half ounces, lived. His head measured eight inches in circumference, neck four inches, foot-length one inch. An ordinary wedding ring slid up over his elbow.

Joey lived; it is remarkable. Perhaps he survived only because a suitable feeding was found. Mother's milk was not available. Borden's Lactogen, cows' milk were tried in turn, and finally a Carnation milk formula agreed. Constant artificial heat was supplied by four

Joey at two and a half months.

hot water bottles; a 94° room temperature was required night and day; he was soaked in protein fat five times every twenty-four hours and wrapped in non-absorbent cotton. Blue or sinking spells left him limp once or twice a night. Some of these were severe enough that 3 minims of Coramine were needed to revive him. Until his sixth day Joey didn't even whine to warn his nurse of anything amiss.

Joey at twenty-seven days of age was limp, jaundiced and incredibly old in appearance. He weighed a scant one pound, nine ounces. He refused to swallow, so was fed by means of a tiny catheter one teaspoonful of formula every hour, day and night, for forty-nine hours. From then on he improved and gradually increased in weight. His colour turned to pink. Once a day he was given two drops of Ostogen, and seven drops of Ferrochloral in water. By the end of the second month Joey was able to take two ounces of formula; the high-pitched squeak was replaced with a normal cry; Joey could perspire and his artificial heat was reduced to one hot water bottle at his feet; eye lashes began to grow; fingernails appeared and he began to wake every two hours for his feedings.

Four months. Note size of doll.

At three months of age Joey ate every three hours, took two and a half ounces of a two-in-six Carnation formula. He eliminated twice a day without an enema, if given five drops of castor oil every ten days. Syrup in the formula merely gave him distress if increased. Hard and fast rules as to feeding or care did not apply with him. His nurse found him a tentative little human. She knew he must be five pounds at least before being discharged from the Outpost Hospital.

Joey, at four and a half months, weighed five pounds, five ounces. He towered fifteen inches in height on tiptoes. Three ounces of formula were taken from an ordinary feeding bottle in less than half an hour, every three hours. Joey smiled fleetingly and developed a temper. He disliked other babies, showing much jealousy if his nurse held one. His measurements were as follows: hat, thirteen inches; collar, twelve inches; boot, two and a half inches.

Joey is the eighth child in his family. He has three sisters and one brother living. To date he seems to be gaining slowly but steadily in weight from reports sent in by his mother, as Joey went home when four and a half months old.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Institute on Family Health Counselling

ISOBEL BLACK

For the week of June 18, the public health nurses of Winnipeg enjoyed the stimulating comradeship of group study on topics which are basic to public health nursing. Our thinking was guided by Miss Frances Benjamin, Parent Education Consultant of the Nursing Bureau of the Michigan State Health Department. Miss Benjamin was brought to Winnipeg by the School of Nursing Education of the University of Manitoba.

In planning our Institute we felt that what we needed most as public health nurses was to improve our methods of family health counselling. We realized that in addition to a knowledge of interviewing techniques, this would require a deepening of our understanding of family living and of the feelings of people as they meet the most meaningful of their experiences within the family. Do we really understand what it means to all members of the family to prepare for the new baby, to adjust to the illness of one member, especially such illnesses as tuberculosis and syphilis? Do we really understand the relationship of parents and children? We were aware of our need to become more understanding people in order to be effective public health nurses. We described our needs to Miss Benjamin and she planned the following topics for discussion:

The Family Today — The Contribution of the Nurse

Maternity — a Shared Family Experience
The Maternity Group

The Parents' Care and Guidance of Children in the Home

The Infant

The Older Child

The Family and Community Agencies — Services to Supplement the Home

The Child Health Conference
The Church, Library, School

The Family Meets the Problem of Communicable Disease

The Essentials of the Interview with Individuals and Parents

Materials:

Useful to Parents in Understanding Their Children and Themselves

The Professional Development of the Nurse

The Veteran Returns to His Family and Community.

It is always reassuring to be reminded of one's importance in a vital cause. During our first meeting we experienced this satisfaction. Among the many highly trained workers helping the family to make the wholesome adjustment necessary for the development of children into healthy, happy and useful members of society the public health nurse has a unique and basic contribution to make. For instance, what other family counsellor is associated with the

family *before* a crisis arises? The public health nurse works closely with families over a long period of time covering normal experiences as well as crises. She is with the family when it meets the most vital experiences concerned with its existence as a family and with the care and guidance of children. During the maternity cycle the public health nurse is close to the family providing guidance in the preparation for and adjustment to the new member. This gives her an opportunity to help all members to find this a maturing experience and to play their parts in giving the baby the best start towards wholesome living.

Once we were sure of our place in helping parents to create the kind of family life which promotes health and the happy adjustment that is such a vital part of health, we were ready to turn our thoughts to the study of how to accomplish our objectives. As we thought together, we realized that we now have knowledge in advance of our ability to apply it. We must increase our skills in working successfully with people. To do this we found the nurse must be a calm, accepting person who can accept a family at its own level, appreciating its assets and willing to allow the members to meet their needs in their own way, using the nurse as a resource person who can help by sharing her knowledge without imposing her solution. She interprets health and the meaning of children's behaviour in this light of normal development. She strengthens the resources already within the family. The nurse must train herself to see the resources the family brings to the situation. What are the strengths of the family? What are the positive factors in the situation? It is so much easier to see problems to solve, the weaknesses of the family and all the negative factors in the situation, that sometimes the assets are obscured. Nevertheless the nurse must be aware of them. It is those strengths that the family will use with our help to solve its problems and build a more healthful way of living. We studied an actual record and found many positive factors in a "problem" family. Although there were many negative factors such as poverty, low level of intelligence, poor house-keeping, crowded living conditions and poor adjustment of a school child, we found a number of values. There was evidence of mutual trust and affection, of the mother's interest in the children, of good meal planning and of an easy, happy home atmosphere. The father was able to work steadily. The school teacher and principal were interested and understanding. There was a good relationship between the nurse and the family. We had to look searchingly to find some of these assets but they were there.

We found also that the nurse must be an observing person if she is to understand the true nature of the situation facing the family, how the various members feel about it and what the positive factors are. She listens, she draws out, she notices and perhaps most important of all she *records* her observations. Later as she studies her record in the objective atmosphere of the office she is able to interpret her observations free from the responsibilities and tensions which may have been present in the home. Her observations become more meaningful and her insight is deepened.

An appreciative regard for children is important for the nurse in her family health work. As she discusses them, showing genuine interest, the mother is drawn out to talk about them also and the nurse learns much about the parents' relationship to the children and about the family life in general. She interprets the normality of growth, development and learning; the relationship of the physical to the psychological, and of past experience to present behaviour and future development. If the parents have this insight they will know how to give understanding guidance.

With Miss Benjamin's help we came to see that the public health nurse can make an important contribution to increasing parent's confidence and giving

parenthood status. It might help parents to realize that they are the most important people in the child's life and that they have a function which can be performed by no one else. Many mothers and fathers have a feeling of failure in their role as parents. An understanding nurse may be able to help them to see the tremendous contribution they have made unconsciously to their children and in this way give them much-needed encouragement. A family record was cited in which this was strikingly illustrated. A new baby was expected and one of the older children, a twelve-year-old boy, had asked questions about the changes in his mother's figure. The parents realized by the questions that the boy had some knowledge about reproduction and was indirectly asking for more information. They felt it was their duty to give him more knowledge of sex but because of their own training they were emotionally unable to tell him the facts. Consequently they felt they had failed. The nurse helped them greatly by enabling them to see that they had already played the basic role of parents in sex education by giving their children confidence in family life, in the relationship of parents with each other and with their children. They had given their son basic attitudes towards life in general which would carry over into his attitudes toward sex. Even if they had to leave the task of fact-telling to someone else they had already successfully accomplished the very important part that only parents can play.

When we were ready to study the interview, we found that our past discussions had given us sufficient understanding of how to establish good working relationships that we could formulate some principles of successful interviewing with little trouble. The same applied to our discussion on the returning soldier and his family. We could understand something of the experience of both the soldier abroad and the family at home during the war and how the experiences of each will relate to the problems of adjustment for both the soldier and his family. The public health nurse, by being an understanding and reassuring person, should be able to help families as they make these adjustments.

While studying the community and how it supplements the home, we saw the work of the public health nurse in strengthening and developing community facilities as she co-operates with representatives of other agencies, and as she helps families to be aware of their community needs and their responsibility in promoting facilities to meet them.

During our work and study we came to see that, "So men can reveal to you aught but that which already lies half asleep in the dawning of your knowledge."*

We are beginning to see that we cannot impose our knowledge. We can only help to reveal to people the rich resources hidden within themselves. The Institute was an experience of this type of learning. Miss Benjamin gave us a masterly demonstration of how this slumbering knowledge may be awakened by skilled leadership.

*Kahlil Gibran — The Prophet.

Combat Exhaustion

Combat exhaustion cases, known as shell shock in the last war and sometimes referred to as combat fatigue or operational fatigue, were treated more successfully in this war because of the high quality of personnel in the field, better methods and techniques, and of the greater importance of the fact that psychiatrists got to the men sooner than ever

before. Army psychiatrists did some of their most effective work right up near the front at the clearing stations.

There was some variation in the treatment given. Sedation, narco-synthesis, hypnosis, and the new technique of group psychotherapy were some of the methods of handling these battle-weary soldiers. The results of group psychotherapy were, in general, particularly encouraging.

Symptoms of combat exhaustion were increasing irritability, lack of interest in letters from friends or family, lack of interest in comrades, and the throwing away of equipment and food.

There was a direct ratio between the number of exhaustion cases and the intensity of combat. The number of combat exhaustion cases was almost always just about one-fifth the number of wounded cases.

Every man has his breaking point, according to psychiatrists. It is just a matter of how much stress and strain is put upon a man and for how long a period. The fact that combat exhaustion cases bore a direct ratio to the number of wounded shows that as the battle became more intense the pressure was just that much heavier, causing more men to reach the breaking point.

A factor that lead to combat exhaustion was the martyr situation. When men were unavoidably marooned from the main body of troops so that the situation seemed hopeless, or when they were on a mission which they did not understand and which seemed futile or when they were isolated and lost their leader, the average man was more likely to become subject to combat exhaustion under such circumstances.

Combat exhaustion did not mean that a man was "yellow", or a coward. A big percentage of the combat exhaustion cases represent men who had had long months of service at the front as effective and brave fighting men. They simply came to the point where the human system could take no more. It is then that the psychiatrists start to care for the ailing soldier.

—*News Notes No.* 28.

Civilian Internees of Jap Prisons

American civilian internees of Japanese prison camps in the Philippines, who have recently been returned to the United States, were found in a survey by nutritional scientists of the Army Medical Department to be on the borderline state of extreme starvation.

According to the report, the food served the prisoners, in addition to being poorly cooked, consisted mainly of wilted greens, moldy corn, dirty rice, and a variety of sweet potato which was often rotten. This soon led to vitamin-deficiency diseases. Relief packages were allowed in the camp only twice during the period of internment, all market vendors were barred from the camp, and the only source of extra rations was the black market.

The report, in listing the effects of malnutrition on the eight children born in the prison camps, noted that only three showed any signs of vitamin deficiency. This was attributed to the mild climate and sunshine of the Philippines. The average weight loss, during the time of internment, jumped from 13.5 pounds in 1942 to 20 pounds in the last six months before liberation.

The most common symptoms still evident in the liberated Americans is digestive upsets, easy fatiguability, and neuritis. Seventy-eight per cent of the internees, however, reported that they felt "fine" a few days after liberation. The rapidity of recovery of the adults and the relatively good condition of the children is a striking example of how quickly the human body will return to normal after semi-starvation.

—*News Notes No.* 28.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Renal Calculi

CATHERINE O'HANLEY

Gladys is twenty-nine years old, pale but well nourished. For the past few years she has suffered periodic attacks of pyelitis with frequency and vomiting. Treated in hospital in 1940, she has sinced enjoyed fair health. Three days previous to her admission hospital in February 4, 1942, Gladys suffered severe pain in lumbar region accompanied by frequency of urination and nausea. On admission by stretcher she seemed to be very ill and was suffering acutely. Rectal temperature was 105, pulse 98, respiration 22, blood pressure 140/90. Murphy drip was started at once and continued for seventy-two hours until she could no longer retain the fluid. Proctoclysis saline and glucose were given. Linseed poultices were applied every four hours to the lumbar area and codeine gr. 1/2 was given for pain. Blood picture showed hemoglobin 65, W.B.C. 26,000, R.B.C. 3,280,000, urinalysis, albumin +, pus +. A blood urea done the following morning showed 150 mg. per 100 cc. X-rays taken the same day revealed stones in both kidneys. After forty-eight hours her temperature became normal, and she seemed better but was unable to retain even water. For the next month, she was given an intravenous daily. Frequency had become considerably worse and large quantities of pus are passed daily.

On March 3 and 14 transfusion of 500 cc. citrated blood was given following which Gladys showed improvement, seemed to gain strength rapidly and was able to eat and retain her meals. On March 23 she was allowed up; four days later she had severe recurrence of pain in right kidney area occurring at intervals.

On April 28 a pyelotomy was performed and a large stone removed from the right kidney. She received regular post-operative care, and made satisfactory progress with the clips removed on the seventh day. Four days later severe pain occurred in the left kidney area with elevation of temperature to 102, pulse 100. Sulfathiazole was ordered grs. xxx to be given immediately then grs. xv every four hours for six doses, followed by grs. xv three times a day. This was discontinued three days later when patient could no longer tolerate the drug. The next day another blood transfusion was given. Nausea persisted for several days necessitating intravenouses of saline and glucose daily. The temperature now was normal, and the patient was allowed out of bed on the twenty-third days for fifteen minutes.

The blood picture of May 26 showed W.B.C. 8000, hemoglobin 75. Though her condition improved the patient was not well. X-ray revealed a stone in the left ureter and the urine was full of pus. On June 9 ureterotomy was per-

formed, and a stone 1 cm. by 6 cm. was removed from the left ureter just proximal to its entrance into the bladder. On the ninth post-operative day chills, accompanied by a sharp elevation of temperature and nausea, occurred. Neoprontosil grs. xxx was ordered and given at once, then grs. xv every four hours for six doses followed by grs. xv three times a day for three days. Thereafter the patient made good recovery and was allowed up on the fifteenth post-operative day. On the thirty-third day she was discharged feeling well but still troubled with considerable frequency, passing a large amount of pus, and having blood urea of 80.

On November 13, 1942, Gladys was again admitted, this time with frequency, difficulty and pain when voiding; she could scarcely tolerate the passing of a catheter, and the urine still contained large quantities of pus. She appeared quite healthy with blood pressure of 120/80. Blood chemistry on recheck was 80. She was given boracic bladder lavage for several days, and hexamine grs. 7-1/2 three times a day for three weeks. After this frequency still persisted, but pain on voiding was not so severe. One the twenty-second day there was an elevation of temperature to 102 with severe pain in lumbar region and vomiting. Neoprontosil was again ordered every four hours. During the three following days Gladys took chills daily, her temperature going as high as 104.8. At this time frequency was much worse and she suffered great irritation. Intravenous was given and argyrol 10 per cent instilled in the bladder. Ninety-six hours later the temperature was normal and, although frequency remained, the irritation was much relieved. Her condition remained much the same until January when a cystotomy was done. One month after the operation, the supra-pubic tube was removed, after which the patient voided without difficulty but suffered intense irritation at times. Six days later she was out of bed but was not feeling well. Another x-ray taken revealed a stone in the left kidney, and she had the usual pyuria.

On March 10, the left renal calculus was removed. Kidney drainage was by means of a bottle attached to the bed. Each day the tube was irrigated with boracic solution and every second day argyrol 10 per cent was instilled into the kidney. The tube was removed on the eighth day. She was allowed out of bed on the fifteenth day. Dressings were changed frequently until the incision had healed. When discharged on March 29, blood urea was 66; frequency persisted but patient felt well. November 12, 1943, Gladys returned for a routine check-up. Examination showed a cystocele and excoriation and redness at mouth of urethral opening. Blood urea was 55 with only a small amount of pus in urine. Urea clearance was 12-27 per cent. Hexamine was ordered, to be continued until cancelled by the doctor. She was asked to return in six months time for check-up.

June 12, 1944, Gladys was admitted for re-check of blood chemistry and urine. This time she had extreme urgency and frequency, and was passing large quantities of pus daily. She now had prolapse of the bladder. She complained of severe pain in her chest also. X-ray taken of chest showed nothing abnormal. Urea was 60, W.B.C. 14,-000, hemoglobin 80, R.B.C. 4,200,-000. Bladder irrigations were given until return flow was clear. Hexamine was continued. On July 4 the patient was discharged feeling quite well, and asked to return later for treatment with penicillin. September 23, 1944 she was re-admitted for treatment with penicillin. She had no particular complaint except for the usual frequency. Urine culture grown for twenty-four hours showed almost pure staphylococci, but no tubercle bacilli. Urine contained pus 4+, albumin 2+, hemoglobin was 70,

W.B.C. 14,000, R.B.C. 3,373,000, urea 70. She complained of marked tenderness in both loins, and had a marked rectocele and cystocele. Penicillin 20,000 units was given every four hours until 1,300,000 units were received. After the administration of penicillin the urine cleared up remarkably. Two negative cultures were obtained; frequency and burning disappeared but recurred to some extent on discontinuance of penicillin. Since discharge from hospital Gladys has been enjoying much better health.

Preparing Material for Radio

JEAN MASON

Radio today vies with the printed word as a means of publishing information. Anyone with a message for the public does only half a job if he does not use radio.

Local nurses' associations frequently have messages for the public which radio can help them give. Radio station managers are usually willing to co-operate by giving time *if they feel that the message is of enough importance to enough people and if the program promises to entertain as well as instruct.*

The simplest type of program is one in which one person speaks for a specified length of time. Unfortunately, this is usually the least effective type of program. Unless the speaker has an exceptionally good radio voice, it is difficult to hold the interest of a radio audience no matter how good the material may be. Both voice and material must be far better than would be necessary if the speaker were addressing an audience whom he could see and by whom he could be seen. An audience in a lecture hall is already interested enough to have made an effort to be present, they can see the speaker (which adds interest), and the speaker can see them and get their reaction and adjust his talk to their mood.

It is, therefore, best, in using radio to give a message, to make use of several voices. The different voices provide interest and change, and the audience gets the impression of being talked to rather than addressed.

Material for panel discussion (or for any other radio program) should always be prepared in advance. The master wits of "Information Please" are the only group of which I can think off-hand who have made a real success of an unprepared and unrehearsed program. A mike in a radio-station studio provides little inspiration, even for the most spontaneous after-dinner speaker or celebrated story-teller — Winston Churchill, your favourite news commentator, Jack Benny, Edgar Bergen, Fibber McGee all read from carefully prepared and carefully rehearsed scripts.

In preparing a discussion script, keep your cast small — three or four is a good number. This makes the script simpler and the program easier to follow. Start with an introduction by the announcer. Make your opening sentence as arresting as possible, but better not try any "stunts"! Have the announcer introduce the other participants, and have each one speak as his or her name is given, so that the audience can couple the name and the voice.

In writing radio scripts there is a form which has become standard because experience has proven it to be best — easiest for the actors and the studio engineers to follow. Write the name of the speaker in capital letters in the left-hand margin. Do not use this margin

for anything else. If you have any sound effects, treat "EFFECTS" as a speaker. When you want an effect, write "EFFECTS" in the left-hand margin just as if "EFFECTS" were a member of the cast. Then write, in capital letters opposite, the effect you want. But beware of too many or too elaborate effects. If you have effects, you have to have a sound-effects man, which costs somebody money and which complicates your production and sometimes leads to difficulties even for professionals. If you need any effects, talk them over with whomever you are working at the radio station well in advance.

Make your dialogue conversational. Let it develop as it might develop if it were spontaneous. Say it over to yourself as you write it. If it doesn't sound natural, rewrite until it does.

Keep speeches short. The shorter the better.

If you have any special instructions for your characters, write them in capital letters and in brackets. For instance, you may want someone to read a certain line with particular emphasis. Write (WITH EMPHASIS) before the sentence. Then, when you want her to resume her normal voice, write (NORMAL VOICE). If you want a laugh or a sigh or a whistle, write it in the same way. It's as simple as that.

End your script with something interesting. Don't let it just peter out. Build up to something. In writing radio drama, we call it "the twist". You don't need a twist on an educational broadcast, but you do need a climax.

Bring the announcer back at the end of the script to tell the audience to whom they have been listening.

In writing a script, you need, roughly, one double-spaced typewritten 8-1/2 x 11 page for each minute on the air. But a lot depends on the type of the script and the cast. So rehearse it in advance, then add or cut as needed, and rehearse again until it is the right length. Keep within your time limit. Don't write quite enough to fill the time allotted to you — at the time of the actual broadcast someone may read more slowly than usual, and if you see your time slipping by too quickly you may get panicky. Better to be a little short.

Have the final scripts typed, double-spaced, on legal-size paper. Double-spacing means easier reading. And legal-size paper means fewer sheets to turn and rattle and perhaps misplace.

Don't break words at the end of a line of a radio script. This means a pause in the middle of the word while the reader's eye travels to the next line.

If you are acting as well as writing the script, remember this: Rehearse sufficiently. Become entirely familiar with your script. Underline words and make other notations which will help you. When rehearsing, practise holding and turning the pages of the script noiselessly. Try your voice in front of the mike before you go on the air, and have the studio engineers show you just where to stand or sit. Don't wander away from the mike or get too close to it during the broadcast. Speak in a conversational tone. Be quick on the pick-up. Be ready to come in as soon as the last word has left the preceding speaker's mouth unless the dialogue indicates a pause for thinking it over, but once you're started, speak a little more slowly than you ordinarily would.

You can get a lot of enjoyment out of radio writing or acting. And radio can do a big job for you.

Good luck!

Preview

What is the most up-to-date information regarding immunization? How much value is the inoculation against scarlet fever? Dr. Lawrence E. Ranta has prepared an authoritative statement for us which will be featured in December.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Tuberculosis Affiliation in Saskatchewan

CHARLOTTE G. CROWE

The November, 1943, issue of *The Canadian Nurse* contained a short item under the caption "Who is to Nurse the Tuberculous Patient". Saskatchewan hopes to answer this challenge by providing affiliation in tuberculosis nursing for student nurses. The results are immediate and long range; the student provides efficient nursing care while learning about tuberculosis; the graduate nurse will be better prepared to deal with tuberculosis when she meets it, and it is reasonable to suppose that more registered nurses will take up tuberculosis nursing after they have had an introduction to this fascinating and worthwhile field.

In setting up the present course the Saskatchewan Registered Nurses Association was approached by Dr. R. G. Ferguson, general superintendent of the Saskatchewan Anti-Tuberculosis League. A tentative curriculum was prepared and presented by the superintendent of nurses at Fort San to the superintendents of nurses of all the schools of nursing in Saskatchewan, to representatives of the Saskatchewan Registered Nurses Association and the Saskatchewan Anti-Tuberculosis League at three meetings held in different centres. A general meeting with the Council of the Saskatchewan Registered Nurses Association, held at a later date, passed the final curriculum and agreed to an eight weeks' course. The approval of the University of Saskatchewan was obtained and the affiliate school made subject to inspection by the Saskatchewan School of Nursing Adviser.

Contracts (as between the League and the Board of each hospital maintaining a school of nursing) were signed. These contracts include agreement of the School of Nursing Hospital to send a specified number of students (with specified basic nursing qualifications) every eight weeks and agreement of the League to provide the educational opportunities as outlined in the curriculum; to pay each student the same allowance as she receives in her home school; to pay transportation to and from the sanatorium and to provide sickness and accident insurance while the student is at the sanatorium. The first group of sixteen students registered at Fort San on June 1 and 4, 1945. By admitting on the two dates it is felt that the students will have more initial, individual attention and also that there will not be a complete change of students on one day at the end of each course.

The curriculum includes a total of thirty-five class hours, which covers lectures, demonstrations and medical conferences. The curriculum is flexible and can be adjusted to include material of special interest to the students. Each student prepares one case study which is

The first affiliate group.

presented as an oral report in a thirty-minute conference with the instructor and several staff members. The students are on a rotation service, that is, operating room, diet kitchen, pediatric, orthopedic and general wards.

The pediatric and orthopedic departments are two special services where the student nurse has an opportunity to observe the child who is not acutely ill but requires long term hospitalization and adults, who being orthopedic patients, present a problem not commonly encountered in general nursing.

The actual nursing of the tuberculous patient is not heavy. A properly followed routine is necessary but this does not in itself become monotonous as patients are sometimes in a sanatorium for years and it is part of the treatment not to let a routine become tedious to the patient. The psychology of nursing the tuberculous patient is different from that used in the nursing, for instance, of the very ill surgical patient. Often the tuberculous patient does not realize the extent of his physical disability nor what is necessary in the restriction of exercise for his complete recovery. It is all very interesting and the student who is successful in attaining a proper balance of sympathy and tact, plus an understanding of the patient's position, has gone a long way towards being able to handle the tuberculous patient.

The Infirmary at Fort San.

Prevention of the disease is, of course, of vital importance. This phase of the work is also dealt with. Most of the student nurses have some knowledge of the effectiveness of B. C. G. vaccination and with further tuition and actual contact with the work being done, the follow-up work in the Districts will be better understood and the League will, therefore, get assistance in their surveys.

Before taking part in nursing at the sanatorium, the student has x-ray plates taken, blood counts, urinalysis and a physical examination by one of the medical staff. A check is also made before the student leaves the institution.

The students work an eight-hour day and a forty-eight hour week. They are assigned day and evening duty only, because it is felt that there are fewer educational opportunities on night duty. Class hours are included in "onduty" time.

The final grade received by each student is calculated from the scores received on special topics, case study and the final examination. The record returned to the student's home school includes a summary of her proficiency reports, a record of the types of cases nursed with the number of patient-days, the final grade and percentile ranking.

The eight weeks spent at Fort San do more for the student nurse than just introduce her to tuberculosis nursing. Of great importance is the change of environment. Situated, as it is, on the shores of Echo Lake, in the Qu'Appelle Valley, the spacious beautifully land-

scaped grounds are in contrast to most of our city hospitals. The student has the benefit derived from associating with nurses from other schools of nursing and she has the opportunity to learn to adjust to a new situation where not only techniques but policies, too, are different.

The social life of the student is not forgotten. There are many seasonal sports such as: tennis, swimming, skating. There is a movie once a week. Picnicking is popular and the dietitian is always ready to be of assistance in planning an outing of this sort.

Standards of nursing that were rigidly maintained heretofore, and have unavoidably been lowered on account of lack of properly trained personnel, are being brought back to their former level and this first group of affiliate students will go down in history as having made a valuable contribution in assisting to make this possible. We realize that the success of the affiliate course will be determined by the results obtained and it will be interesting to note how the students react to this type of work when they leave their schools of nursing.

The Welfare of the Generation

The welfare of the growing generation, the creation of all conditions necessary for the upbringing of healthy, happy and well-educated citizens, has been the special care of the Soviet Government from the very first days of its rule.

No country in the world has such a wide-flung network of children's institutions as the Soviet Union. Nurseries, kindergartens, boarding schools, schools and children's clinics and hospitals were opened in all cities and villages, in the most remote corners of our vast country.

In the grim years of the war the Soviet Government has devoted particular attention to the younger generation. During the first stage of the war, tens of thousands of children were evacuated to the eastern regions of the country and the necessary measures were immediately taken to ensure qualified medical attention for these youngsters. The fulfilment of these government decisions was laid upon the People's Commissariat of Public Health which at once made preparations for the opening of additional consultation centres, polyclinics, hospitals and children's homes.

A particularly great increase has taken place in the number of nurseries existing in the RSFSR since the war began. Whereas there were 2,797 permanent nurseries with 162,940 cots in the thirty-six regions of the republic on January 1, 1941, by 1944 the permanent nurseries were able to accommodate 507,000 children and this year this number will be increased to 634,000.

Particularly wide-scale work in this direction has been carried out by the public health organizations in the villages and in the outlying regions of the Soviet Union. During these years 55,465 cots were added to the nurseries in rural regions, this being 44 per cent of the prewar number.

The "Molodaya Gvardia" Children's Home — The children listen to a fairy tale told by their teacher.

The children study music.

Dinner-time.

As millions of women went to work in factories and plants, the brunt of the care for the health and welfare of their children was laid upon the shoulders of the nursery personnel, and many improvements were made in the care of the babies and special sections for sick children were opened in all nurseries, which greatly eased the life of the mothers.

However, the organization of new nurseries did not exhaust the scope of the measures taken for maternity and child welfare. Since the war broke out, no less attention has been paid to the formation of new consultation centres and polyclinics for children. In peace-time the RSFSR had some sixteen hundred consultation centres for mothers and children. In the course of the first two years of the war this number had grown to 1,756 and is steadily increasing; it is scheduled to reach 3,374 in 1945. This growth is particularly noticeable in certain regions. For instance, 99 new consultation centres, of which 77 are in remote villages, have been opened in the Urals and in Siberia.

A radical change has also taken place in the nature of the work itself. Every one of them now has a staff of highly qualified doctors, nurses and health visitors. Particular attention is paid to weak and backward children who are kept under special observation and receive increased rations, cod liver oil, electric treatment and so forth.

It is natural that the war should have caused certain difficulties with the supply of provisions and other articles of prime necessity but, thanks to the tireless efforts of the Government, this has in no wise touched the children. The increase in the number of milk distributing centres is characteristic in this respect. In 1940 these centres distributed some 80,000 portions, and during the past year the children received about 186,000 portions of excellent milk in spite of the fact that the livestock breeding regions of the country had been decreased as the result of the temporary occupation.

At the same time, a considerable increase has taken place in the number of children's homes. In 1941, about 6,568 children were being brought up in these homes, and at present 25,000 children of servicemen are being maintained in like institutions.

In order to improve the food supply for children a decision was passed to provide the children's institutions in the city of Vladivostok with additional provisions to the sum of 308,000 rubles — 2,602 kg. of chocolate, 50,000 cans of condensed milk and so forth. Similar measures were taken in other regions of the country. Also, in the majority of autonomous republics, regions and districts, special subsidiary farms were formed, the products from which went to improve the children's diet. The Khabarovsk regional executive committee has given the children's institutions 150 cows; Kalinin Region — 120 cows, and so on.

For older children a large number of special dining-rooms, catering to 295,000 youngsters, were opened. At present, there are no regions or districts in which such dining-rooms do not exist, the majority of them catering to children of servicemen.

N. MANANNIKOVA
Assistant People's Commissar of Public Health of the RSFSR.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Placement Bureaux Institute

An institute for directors of Nurse Placement Bureaux, the first in Canada under the auspices of the Canadian Nurses Association, was held September 5-15, at the University of Manitoba, Winnipeg, with representatives from eight provinces present.

Dr. Frances Triggs, Ph.D., personnel consultant of the American Nurses Association, was guest lecturer. The first five days were devoted to group discussion and the last five days to consideration of personnel management problems. The meetings, September 10-15, were open to administrators of hospitals and public health organizations, and to nurses who were especially interested in personnel work.

A complete report of this institute will appear in a later issue of *The Canadian Nurse*.

Youth Training Plan

Due to the fact that we have received so many inquiries about the Youth Training Plan from various provinces, we decided to write to each Registered Nurses' Association to find out which provinces were receiving benefits for student nurses. The replies were as follows:

Alberta: Dominion-provincial financial aid is now available in an amount of one hundred dollars each to girls of eighteen years and over who are interested in nursing as a vocation, but whose parents are unable to finance the three years training period. This grant does not have to be repaid. Fifty dollars will be paid after the student has been definitely accepted by a school of nursing and fifty dollars on successful completion of the preliminary term of approximately four months. The grant will be restricted to those who sign the agreement that they will make their services available as nurses on graduation, either by enlisting in the armed forces or by nursing in a war industry, hospital or similar public institution, or in departments of public health.

British Columbia: The provincial Department of Education allocated $2,000 of Dominion-Provincial Youth Training Plan Fund for bursaries for student nurses in 1944-45 and $3,000 for the current fiscal year. The entire amount was used last year, and many requests are being made for bursaries for this year.

Manitoba: 1. The purpose of the loan fund is to assist nurses in training, who, without financial assistance, could not enter on or continue their training.

2. All trainees must sign an agreement that, upon graduation, they will serve as nurses in the armed forces, war industries, public health work, approved hospitals or similar government institutions.

3. The maximum loan to any student shall be two hundred dollars per training year.

4. Assistance shall be given in the first instance as a loan, but one hundred dollars of such loan shall be cancelled for one year's service, as designated in Regulation No. 2, and fifty dollars additional for each additional six months service.

5. Any trainee who breaks the agreement designated in Regulation No. 2 (except for reasons beyond her control) shall immediately be required to repay the loan in full, with interest at the current rate.

6. If granted a loan, the applicant shall sign a promissory note for the amount of the loan, payable to the Province of Manitoba, Department of Education, Canadian Vocational Training Branch, and may be required to provide security.

7. In the event of a loan being granted to a minor, the promissory note which she signs must also be signed by a person meeting the approval of the Loan Committee.

New Brunswick: No provision has been made for student nurses in New Brunswick through the Youth Training Plan.

Nova Scotia: There are no grants for nurses under the Youth Training Plan. This is to be brought to the attention of the executive of the provincial Registered Nurses Association at their next meeting.

Ontario: Up to the present the Ontario Government has not participated in the Dominion-Provincial Youth Training Plan. No subsidies have been available from this source for student nurses. It is the intention of the Registered Nurses Association of Ontario to make inquiries as to the attitude of the present Government in this matter.

Prince Edward Island: No grants for nurses under the Youth Training Plan.

Quebec: Bursaries are available for students attending provincial universities in any year or in any faculty. The maximum of these scholarships is three hundred dollars, 50 per cent of which is given as a grant and 50 per cent as a loan, repayable one year after the student has left the university.

Nurses taking courses in approved hospitals may also benefit by the annual scholarships of one hundred dollars given as a full grant, provided they agree not to engage in private service for a year after graduation.

A report from Miss Upton, executive secretary, Registered Nurses Association of the Province of Quebec, states that since 1943, when student nurses were first included in the plan, more than five hundred students have received financial assistance from the fund created by federal-provincial co-operation. The Committee of Management, R.N.A.P.Q., recommends a continuance of the Youth Training Plan as applied to student nurses.

Saskatchewan: The maximum assistance available is one hundred dollars per year. In order to receive a second or third grant, it is necessary to submit a request for it, together with an affidavit from the parent or guardian covering his present financial position, and a letter of recommendation from the director of nursing. All applications go through the registrar of the Saskatchewan Registered Nurses Association.

In a letter received recently from Mr. R. F. Thompson, Director of Training, Department of Labour, Canadian Vocational Training, the following appears: "Student aid schedules are in effect between this department and all provinces, but assistance to nurses is only provided for in the province of Quebec and the four western provinces. Such assistance was evidently not considered necessary in the Maritimes or in Ontario, as no request was made to us for those provinces to include nurses within the provisions of our schedule."

Canadian Hospital Council Meeting

The Canadian Nurses Association was represented at this meeting in Ha-

milton on September 19-21, 1945, by the president, Miss F. Munroe, and Miss Winnifred M. Cooke, assistant secretary.

The chief topics on the agenda were (1) the personnel situation; (2) pensions for hospital employees; (3) rehabilitation of demobilized men and women; (4) training of hospital administrators; (5) hospital construction; (6) hospital finance; (7) health insurance.

Of particular interest to nurses was the report of the Committee on Nursing and Nurse Education presented by the chairman, Miss Blanche Anderson, assistant director of nursing, Ottawa Civic Hospital. Other members of this committee are as follows: Sister Anna, All Saint's Hospital, Springhill, N.S.; Marion Myers, instructor of nurses, Saint John General Hospital, N.B.; Rev. Sister Madeleine de Jesus, chairman, Council on Nursing Education in Canada, Catholic Hospital Association, c/o University of Ottawa School of Nursing; Frances Upton, registrar, Registered Nurses Association of the Province of Quebec, Montreal; Rev. Sister M. Magdalen, registrar, Prince Edward Island Registered Nurses Association, Charlottetown; Rev. Sister Delia Clermont, St. Boniface Hospital, Man.; Kathleen W. Ellis, registrar and inspector of nursing schools, University of Saskatchewan, Saskatoon; Margaret Fraser, superintendent of nurses, Royal Alexandra Hospital, Edmonton, Alta.; Catherine M. Clibborn, assistant director of nurses, Vancouver General Hospital, B. C.

A request was made that the future chairmen of this committee be granted the privilege of attending the executive meetings of the Canadian Nurses Association, so as to be able to interpret nursing, on a national basis, to the Canadian Hospital Council. Whatever affects nurses or nursing very definitely affects hospitals, and, therefore, should be of interest to the Canadian Hospital Council.

Miss Anderson indicated in her address that the present situation in nursing shows that the nursing personnel in hospitals and in other fields of nursing has faced with increasing difficulties the problem of meeting the need of the essentials of good nursing care. The unessentials have been reduced, nursing procedures simplified, and the work carried on with a degree of efficiency that has earned sympathetic understanding of nursing problems on the part of hospitals, doctors and the citizens of Canada. The weakness of the graduate staff nurse is her inexperience and her lack of preparation. There has been a marked decrease in the number of general duty nurses during 1944-45. Some of the reasons given were: (1) The appeal of change of work and different environment; (2) lesser responsibility; (3) easier hours of duty; (4) salaries which are higher.

The number of student nurses increased slightly in 1944. Clinical facilities in special services, teaching and supervisory staff, as well as living accommodation, have been stretched to a point at which further increase is undesirable until adjustments can be made.

It was felt by all members present that nursing education should receive the financial support of the Government, as do all other branches of education. Nursing service is essential to any community.

Tribute was paid to the married nurse and to the nurse who had come from retirement back into the field of nursing to render service during the war years.

It was suggested that the Government be asked to delay the educational and financial benefits for military nurses for two or three years, so that they could help out in the present hospital situation.

The domestic staff was a problem with which all hospitals were faced, and no solution found.

The overcrowding of hospitals which has been continuous, is one of the most trying difficulties with which nurses are faced. This results in decreased working space, increased physical effort, is uneconomical of time, defeats interest and pride in a finished piece of work, and is unhygienic for patient, nurse and other workers. Good bedside nursing cannot be carried out under such conditions.

The future makes many demands upon nurses: (a) Publicity campaign to bring before the minds of the public the essential value of nursing service. (b) If an adequate flow of students into our schools of nursing is to be maintained, it is necessary that nursing education, conditions of employment, and financial returns compare favourably with other employment of comparable requirements and responsibilities. A public health nurse with post-graduate university course should be found on the staff of every general hospital, to interpret community health to staff and patients. Legislation should be secured for the preparation and licensing of all subsidiary workers. If these workers are introduced into hospitals, it will necessitate increased supervision and responsibility for the graduate staff.

The maintenance of a satisfactory staff is paramount. There should be provision for leave, with salary and expenses, for attendance at nurses' conventions; for refresher courses; observation periods at other institutions, and for long and short-term bursaries for clinical and university courses; some inter-hospital government annuity or a contributory pension scheme similar to that recently established for the Victorian Order of Nurses; the advisability of having capable nurse administrators to act in a technical, advisory capacity, to strengthen the building committee of hospital construction—many omissions and inconveniences would thus undoubtedly be avoided.

The post-graduate courses in universities and courses available in hospital schools and added experience arrangements in hospitals were all listed in *The Canadian Nurse*. See the July, 1945, issue for details.

Other activities and interests mentioned in the report were as follows: (1) Affiliations in tuberculosis nursing; (2) placement bureaux; (3) UNRRA; (4) the brochure for the returned nursing sisters; (5) labour relations; (6) masks; (7) labour exit permits.

No doubt this paper will be printed in detail in the *Canadian Hospital* magazine. We would advise all nurses to read and study the report in detail, and suggest that it may be used for group study within the next few months.

Reprints

In response to an unexpected demand for copies of the articles in the series "Nursing and National Health" which recently appeared in newspapers across Canada, we have had these articles bound in a booklet. Copies are now available at National Office at forty cents per copy.

A third in the series "Discussion on Nursing" is now ready for distribution. These scripts are prepared for "live air" on the radio, but we were very much interested to learn that they have been adapted on several occasions for use over imitation microphones in high school and nursing school auditoria. We think this suggestion worthwhile passing on.

White, for years the standard paint for hospitals, is giving way rapidly to soft tints, even in the operating rooms. The softer tones eliminate glare and give a light which is easier on the eyes of patients and attendants, with a consequent boost to morale.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Proposed Changes in the Preparation for Nursing

Examining the proposals

In June, 1944, certain proposals concerning nursing education were made. To many nurses, these proposals were not really new or particularly startling: to others, they seemed radical and disturbing.

We may assume that in a democracy anyone has a right to make a suggestion, and that anyone else has a right to question it. But we also think it may be assumed that nurses in good standing who make serious proposals to the Canadian Nurses Association do so in good faith and in what they conceive to be the interests of nursing: and we believe that those who object to the proposals should examine them carefully and make quite sure what is being proposed. The proposers should not be accused, instantly and automatically, of being willing to "lower the standards of nursing." Incidentally, more than one member of the public has suggested recently that professional standards are sometimes invoked more in the interests of the profession than of the public. Unwarranted assumptions from a proposed plan do not help the cause of nursing.

Developments in other countries

It may help to secure a calm and reasoned consideration of the possibility of change in our nursing system if we realize that similar suggestions are being made in other countries, and that in fact some of these countries have taken action on them, and are trying out, in various forms, experiments to try to meet the nursing needs of these countries. In England an assistant nurse is now recognized by law, a course of training of two years is outlined, and the rules for admitting these nurses to the register of the General Nursing Council are now being drafted. Incidentally, it is proposed to teach a much greater number of somewhat advanced nursing techniques to this person than have ever been proposed for our assistant nurse.

In New York, the Practice Act provides for the training and licensing of practical nurses as well as professional nurses.

In India, during the years of the war, 3500 auxiliary nurses have been trained, and will now be available for civilian hospitals.

New Zealand in 1939 passed an amendment to the Nurses and Midwives Act, providing for the training and registration of nursing aides. The period of training is two years, followed by a state examination.

Fuller accounts of these experiments will be found in the nursing journals of the countries concerned. The point is that various countries recognize the need for change, and that some have not been afraid to try out new methods. Here, though the nursing profession hesitates to admit it, we are actually producing and using at least three kinds of nurse, but we are doing so in an unplanned and haphazard way.

Choosing the type of nursing preparation

It has been suggested (and much controversy has followed the suggestion)

that two types of professional preparation should be made available. One, the short course, perhaps two years in length, would prepare, as simply as possible, a skilled clinical (and registered) nurse; the other, four years in length, would give just as thorough a clinical training, but would do this as part of a much broader educational content, so that the foundation would be laid which would enable this nurse to progress to the teaching ranks of the profession. Here the word 'teaching' is used in a broad sense to include public health nursing as well as the teaching and administrative work in hospital nursing.

It has been asked how a young woman is to know whether she wants a clinical or a clinical-teaching preparation. Unfortunately, young people leaving high school do not always know definitely what they want to do, but a choice has to be made. If the choice is wrong, then it is a matter either of abiding by it, or of starting afresh. Many women who have prepared for teaching later turn to nursing, and take the complete preparation for it. The occasional nurse decides that she should have gone into medicine, and does not question the necessity for taking the medical course. As personal and vocational counselling services develop in high schools, girls will be better equipped to choose their professions. On the other hand, many young women would experience no difficulty at all in deciding on which type of nursing preparation they wanted.

It has also been asked why it would not be possible to arrange the shorter and the longer preparations in such a way that a person who had had the simpler clinical course could later transfer, and in say two additional years, complete the longer course. The answer is simply that the two would be different from the beginning. The four-year preparation would have to be given in a university and would include a much more extensive foundation in sciences and public health; and these, with certain other subjects, are the reason for the greater length of the course. Thus it would not be a question of simply adding on certain things to the shorter preparation; the two courses, being for different purposes, are different throughout; and the decision as to which is desired would have to be made at the beginning. However, with the expectation that some nurses would wish to step across from the junior to the senior group, (providing they had the necessary entrance requirements for university work), it is reasonable to assume that some allowance of time could be made upon their behalf.

Our next article will discuss the question: "Would the 'teaching nurse' be able to nurse patients?"

Finding Orthopedic Defects Important

Every child discovered to have any orthopedic defect, no matter how slight, should be considered a potential cripple and every effort should be expended to alleviate or control the condition. It is during the school age period that good posture habits can be effectively established and existing orthopedic deviations readily corrected, thus ensuring a healthier, happier adult life.

The teacher, through her daily association with the children, is in an excellent position to render a very valuable service in such a program. If the school nurse will see that the teachers are given an understanding of the problem and the part they can play in helping to solve it, she will be more than repaid by their contribution . . . the teachers can be urged to be on the alert for any limps, peculiar gaits, abnormal function of the arms and hands, habitually poor posture, tendency toward fatigue, and any other conditions that show deviations from the normal functioning of the body.

An examination by the orthopedic surgeon will determine whether these postural deviations are functional and can be corrected by the application of exercise therapy and other simple corrective measures; or whether the condition is structural.

—*Abstract from E. M. Johnson, Public Health Nursing,* 1945, *Vol.* 37: 472.

Interesting People

Margaret O. Cogswell, B.A., graduate of the school of nursing of the Royal Victoria Hospital, Montreal, has recently been appointed as the director of the newly organized Nurse Placement Bureau with the Alberta Association of Registered Nurses.

Miss Cogswell has the breadth of background which is so essential in a vocational counsellor. Prior to entering her school of nursing, she had useful experience as a high school teacher. After two years' service as head nurse on a men's medical ward at the Royal Victoria Hospital, Miss Cogswell received her training in public health nursing at the McGill School for Graduate Nurses. Following a brief period of relief work with the Alberta Department of Health, she returned to hospital administration at the Royal Alexandra Hospital, Edmonton. For the past year she has been head of the teaching department and science instructor at R.A.H. To round out her experience before assuming her new duties, Miss Cogswell is serving as a general staff nurse in a small community hospital. She has done excellent work throughout and understands the problems of both the hospital administrators and the staff nurses. Miss Cogswell has the happy faculty of being able to see the other person's point of view and of assessing difficulties fairly and honestly. These qualities, combined with her natural diplomacy, and all well mingled with a sense of humour, augurs well for the success of the new placement and counselling service.

The Victorian Order of Nurses for Canada has been pleased to announce the appointment of **Esther Robertson** as national supervisor of the Western branches. A graduate of the school of nursing of the Royal Victoria Hospital, Montreal, and of the public health nursing course, McGill School for Graduate Nurses, Miss Robertson has taken further post-graduate study at Teachers College, Columbia University, during recent summer sessions.

Miss Robertson has been a member of the Montreal staff of the V.O.N. for the past nine years and since 1941 has been the supervising nurse of the North District. Keenly interested in professional problems, she has served on many committees, and, like most truly busy people, always finds time to do all the extra things asked of her. We know that her many friends and associates will regret

MARGARET O. COGSWELL

ESTHER ROBERTSON

FRANCES H. WAUGH

her leaving Montreal, but we are sure a warm welcome awaits her in the West.

Our very best wishes go with Miss Robertson for success and happiness in her new work.

New developments create new opportunities for nurses. With the passing of the Act for the training, licensing and regulation of practical nurses in Manitoba, **Frances H. Waugh** relinquished her position as assistant to the executive secretary of the Manitoba Association of Registered Nurses to become the first registrar and consultant for the practical nurses under the Department of Health and Public Welfare.

Little Studio, London

CORA M. BROOKS

After securing her arts degree at the University of Manitoba, Miss Waugh graduated from the school of nursing of the Winnipeg General Hospital. After a post-graduate course and a year's experience in surgery, Miss Waugh further prepared herself by taking the course in teaching and supervision in schools of nursing at the University of Minnesota, following which she served as instructor with the schools of nursing in Portage la Prairie and Grace Hospitals. The new development under Miss Waugh's guidance will be watched with keenest interest.

Helen Estelle Schurman, who for the past fifteen years has held the position of university nurse at Acadia University, Wolfville, N.S. has recently been appointed superintendent of nurses at Eastern Kings Memorial Hospital in Wolfville. A graduate of Acadia University and of the school of nursing of the Royal Victoria Hospital, Montreal, Miss Schurman took her public health nurse's training at the University of Toronto. She has shown outstanding ability in her health program with the hundreds of students at Acadia and is highly regarded by her townsfolk in Wolfville.

Gladys Tanner has been appointed superintendent of the Kincardine (Ontario) Hospital after serving for five years as assistant superintendent. A graduate of the school of nursing of the Brantford General Hospital, Miss Tanner did private duty nursing before joining the staff of the Kincardine Hospital.

Cora Marcella Brooks, who served in Newfoundland as a nursing sister with the Royal Canadian Navy, has been appointed as director of nursing education at the General and Marine Hospital, Owen Sound, Ont. Miss Brooks, who graduated from the Woodstock General Hospital, winning the Dunlop award, has had a wide experience in nursing. After several years of private duty and work with pediatricians as nurse assistant, she took post-graduate work in surgery at Johns Hopkins Hospital, Baltimore. She received her certificate as instructor of nursing at the University of Western

Ontario, London, Ont. She served in the operating theatre at the Victoria Hospital, London, and at Queen Alexandra Sanatorium, Byron, immediately prior to her new appointment.

Miss Brooks has been very active as an instructor with the Canadian Red Cross Society both before and during the war.

Zeta Hamilton has been appointed as the new superintendent of the hospital at Galt, Ont. Previously, Miss Hamilton had successfully administered the school of nursing at the Stratford General Hospital for sixteen years.

Mrs. Lennie E. MacPherson has assumed the duties of acting superintendent of nurses at the Nova Scotia Sanatorium in Kentville after serving on the staff of the Toronto Hospital for the treatment of tuberculosis in Weston, Ont. Mrs. MacPherson has had broad experience in a variety of hospitals in United States and Canada.

After almost ten years of efficient service as superintendent of nurses at Falconwood Hospital, P.E.I., **Mrs. Ruth (Rayner) Dignan** has resigned. Her place is being filled temporarily by **Mrs. Esther Sellers**, who for the past few years has been on the staff of the Montreal Convalescent Hospital and the Provincial Sanatorium in Charlottetown.

Isabel Davies, A.R.R.C., has retired from active hospital duties. Miss Davies has been supervisor of the operating rooms of the Montreal General Hospital since her return from overseas and retirement from the R.C.A.M.C. in 1919.

Upon her graduation from the M.G.H. School for Nurses in 1908, Miss Davies joined the hospital's nursing staff as an assistant in the operating room, a position she held continuously until 1915, except for a short period in 1913 when she took up private duty nursing. When No. 3 (McGill) General Hospital was organized in 1915, Miss Davies was invited to take charge of the operating room and proceeded overseas with this unit as part of the Canadian Expeditionary Force. Miss Davies remained with that hospital until its return to Canada in 1918, when she continued her military service as supervisor of the operating room at Ste. Anne's Military Hospital. For the conspicuous services Miss Davies rendered during her period of military service she received the decoration of an Associate of the Royal Red Cross.

Clara E. Jackson christens the H. M. S. Rosamond.

In presenting Miss Davies with a purse containing Victory Bonds as a gift from the present members of the Consulting and Attending Staffs, Dr. J. Guy W. Johnson paid high tribute to Miss Davies' efficiency and the outstanding and loyal service she has given to the hospital over a period of many years. Some three hundred guests were present to extend their best wishes for the future to Miss Davies.

Capt. (Matron) Cecil M. MacDonald, A.R.R.C., who has recently returned from four years service in England, Italy and the North Western European theatre of operations, has been appointed to fill the vacancy created by the retirement of Miss Davies.

A unique honour came to a well-known nurse recently when to **Clara E. Jackson**, superintendent of nurses at the General and Marine Hospital, Collingwood, Ont., came the privilege of christening a new naval vessel, the *H.M.S. Rosamond.*

Nancy Dunn, M.B.E., who pioneered in the development of public health nursing in the Peace River area in British Columbia, has launched on another adventure by taking over the supervision of the health of the citizens in Telegraph Creek, Northern B.C. Her territory co-

vers nearly three hundred square miles, the remote settlements of which can only be reached by dogteam and plane. Since the nearest doctors are some two hundred miles away, Miss Dunn has recently completed special post-graduate courses in Vancouver and Victoria to fit her for any and every eventuality.

Obituaries

Beatrice Eileen Cryderman died recently in Bowmanville, Ont. A graduate in 1930 of the school of nursing of the Toronto General Hospital, Miss Cryderman had been engaged in public health nursing in Toronto.

Agnes Findlay died recently in Toronto. Miss Findlay graduated from the Presbyterian Hospital, New York, in 1906. She has resided in Toronto since her retirement from active work in 1938.

Agnes Lee Inkster died recently at Salmon Arm, B.C. Member of a pioneer Manitoba family, Miss Inkster was a graduate of one of the first nursing classes of the Winnipeg General Hospital. After her graduation she served for a time as matron of the Lady Minto Hospital at Rat Portage. In 1909 she moved to Salmon Arm where she spent the rest of her life in service to her fellows.

Margaret (MacKay) Wall died recently in Vancouver. Born in Scotland, Mrs. Wall received her training in Manchester, England. She served overseas in World War I and later nursed at Hartney, Man.

Geriatrics

Probably the greatest changes in hospital planning have to do with the field of geriatrics. The progress of medical science is throwing not hundreds or thousands but literally millions of people into the age group in which the principal diseases are those of senescence and decline. During the last decade these patients have been classified as uninteresting cases or not eligible for hospital care. In the future it will be important that hospitals consider their proper responsibilities as centres for the care and rehabilitation of these patients.

The day of the home for incurables is past. The day of the rehabilitation centre is dawning. In addition to careful medical supervision, all too often lacking in the past, hospitals must plan for greatly increased facilities for occupational therapy, which is the key to the care of these people.

A longshoreman who has outlived his vocation may quite easily be shunted to a bed as an invalid for the rest of his life. With proper application of occupational therapy methods it is perfectly possible to develop in the same person an entirely new attitude toward a new occupation which will convert him from a chronic invalid to a self-supporting and useful citizen.

The requirements are planning, personnel and understanding of the problems involved. The convalescent pavilion or rehabilitation unit should be a part of every hospital that is attempting to do its full job for its community.

—*The Modern Hospital.*

Preview

Turning every possible opportunity into a learning experience for the student is an old story to the good clinical instructor. A patient with a paralyzed bladder provided the material not only for the teaching of actual techniques but also for very much more in understanding of the patient when Clara R. Aitkenhead taught her pupils the care of the case which Dr. S. A. MacDonald will describe for us. Watch for both of these interesting articles in the December issue.

STUDENT NURSES PAGE

St. Paul's Goes Recruiting

ANN BEECHINOR

Student Nurse

School of Nursing, St. Paul's Hospital, Saskatoon

Under the auspices of the Alumnae Association of St. Paul's Hospital, Saskatoon, an interesting function in the form of a publicity program was held recently at the nurses residence, when the graduating classes of all the city collegiates were invited to come and pay a visit to our hospital.

Guided by the members of the Alumnae, the high school girls toured the hospital, the medical and surgical wards, as well as the special departments, in order to give them an idea of the everyday life of a nurse in her actual bedside nursing. Then the girls were taken through the spacious residence where they saw the lovely bedrooms, beautiful reception rooms, the library and study rooms all with the comfortable and home-like atmosphere. It amused the girls to see the brightly-coloured array of articles in each nurse's room, and the pennants, all of which are very precious to each nurse because of their connection with home.

Later, an enjoyable get-together was held in the auditorium. A short program consisting of a few musical selections along with some interesting talks were given by the members of the school of nursing. Capably conducted by Miss Marvalon Robinson, the Alumnae president, the program opened with a stimulating talk by Miss Velma MacDonald, a freshman student. Miss MacDonald outlined in general the three years course, indicating the advance in learning and work through freshman, junior and senior years. She spoke of the wide field of opportunity which lay open to a graduate at the end of her course. Miss Ann Beechinor, a junior student, then gave a more informal account of an average nurse's day, from the sound of the six-thirty buzzer in the morning to the clang of the ten-thirty bell at night. She showed that, though it is a busy life, it is full of interest and enjoyment.

On behalf of the graduating class, Miss Wensley told her audience that, "Although the road be long and rough, there is at the end the happiness of knowing my duty is well done". The classes every day, the clinical work, the joys and the sorrows that constitute the life of a nurse seem to balance themselves at the end of the road. Despite the difficulties and misfortunes, the speaker stated emphatically, "I would do it again, anytime". Miss Eleanor Pfeiffer, a student of the combined studies, explained the university course in nursing as carried out in Saskatchewan, and informed the girls how to enrol in such a course. The hospital which the student selects provides the professional and clinical aspect, while the university is responsible for the academic studies and the conferring of degrees. At the completion of this five years, a nurse is en-

titled to the degree of Bachelor of Science in Nursing.

Tea was served after the program, during which the student nurses chatted informally with the collegiate girls.

The afternoon proved a success for the girls were well pleased with their visit to the hospital. Any bystander could overhear them saying to one another, "You know, after what I saw this afternoon, I think that I would really like to be a nurse".

Book Reviews

Personnel Work in Schools of Nursing, by Frances O. Triggs, Ph.D. 237 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1st Ed. 1945. Illustrated. Price $3.25.

Reviewed by Kathleen Mary Stanton, R.N., B.Sc., Lecturer, McGill School for Graduate Nurses.

This book should be most instructive for those who teach and supervise student nurses both in the class-room and on the wards. It is generally recognized in modern educational practice that teaching is essentially a process of stimulation and guidance through which the student learns and this book is an exposition of this fundamental process. Dr. Triggs realized the need for such a book because she possesses the attribute of caring how workers and learners develop and especially the student nurse. Therefore, this publication should be a most valuable tool in the hands of those who are responsible for the professional growth of the student nurse.

The book is divided into four parts: Part 1 reviews the fields of psychology and physiology very briefly, assuming that most instructors in schools of nursing have had some background in these subjects. The author places special emphasis upon the sympathetic relationship between the student and the counsellor as an essential factor in effective counselling.

Part 2 outlines the qualifications of the counsellor. It also deals with the counselling program and presents concretely the problems that the student nurse has to face, treated under specific situations. A final application is made separately to each of the various aspects of counselling, namely, educational, vocational and personal.

Part 3 deals with tests. This portion of the book should be particularly helpful to teachers and supervisors who have not made a special study of the purpose of testing and types of tests that are now being used in the field of professional education.

Part 4 brings the content of the book to a focus by making personal application to the "Story of a Student".

The book has added merit in that each chapter is supplemented with excellent reference books by outstanding authors, including: Sandiford, Peter: Foundations of Educational Psychology; Shaffer, Laurance Frederic: The Psychology of Adjustment; Strang, Ruth: Behaviour and Background of Students in College and Secondary School.

A carefully selected bibliography on personnel work in schools of nursing is listed at the end of the book.

This text is not highly technical; its merit lies in the fact that it can be used as a practical medium by all superintendents of nurses in interpreting the purpose and scope of a program of educational guidance in schools of nursing upon which sound planning can be based.

Public Health and Welfare Reorganization in Canada, by Harry M. Cassidy, Ph.D. 464 pages. Published by The

Ryerson Press, 299 Queen St. W., Toronto 2B. 1st Ed. 1945. Price—paper bound, $3.50; cloth bound, $4.50.

A companion volume to his Social Security and Reconstruction, Dr. Cassidy states his purpose here is "to analyse the problem of reorganizing and developing the provincial and local health and welfare services so as to fit them into a national plan of social security". He predicts that "drastic changes in organization and administration are required before the provincial and local social services in Canada can reach high standards".

In outlining the premises for provincial planning, Dr. Cassidy summarizes the proposals contained in the four national plans which have been submitted to date — the Marsh plan, the Heagerty report, Miss Whitton's proposals and his own suggestions — and points out similarities and differences.

Part 2 describes in detail the developments which have taken place in British Columbia, which Dr. Cassidy credits with being "progressive as compared with others (provinces) at least in Canada". Part 3 outlines the status of the health and welfare services in the other provinces. Part 4 points to "The Road Forward". Here the major flaws in the present systems are delineated and corrective measures suggested.

The data which this book contains are very well worth the careful study of everyone concerned with health and welfare practices. It should be a "must have" in every public health organization library.

New Steps in Public Health — twenty-second annual conference of the Milbank Memorial Fund, April, 1944. 148 pages. Published by the Milbank Memorial Fund, New York. 1945.

Reviewed by Helen G. McArthur, Superintendent, Public Health Nursing Branch, Department of Public Health, Alberta.

If public health workers are tempted to feel satisfied with their accomplishments and procedures, or, on the other hand, feel they are lost in a maze of problems with no sign-posts to guide them ahead, here is a book that should help shatter these states of mind. The volume contains twelve papers prepared by outstanding American public health authorities and one Canadian, Dr. F. F. Tisdall of the University of Toronto Medical School.

Seven of the papers are in the field of nutrition, expressing not only our growing realization that nutrition deserves a place of major importance in our public health and medical programs, but indicating that research in this field is giving us many guides for more effective public health work. Of particular interest are the papers "The Importance of Prenatal Diet" and "Nutrition — Its Place in our Prenatal Care Programs" as well as the papers on "Industrial Health and Nutrition."

The description of the Peckham Experiment gives a practical demonstration of how our public health horizons could be broadened. "The Peckham Experiment was indeed a study of living structure of society by physicians trained in social medicine and human biology."

Some of the papers hit hard! G. St. J. Perrott, chief, Division of Public Health Methods, U. S. Public Health Service, says, "Since the time of Civil War the high proportion of physical defects found among young men being examined for military service has been viewed with alarm. The only result observable in eighty years, however, has been a number of papers by medical statisticians. It is hoped that the present results will draw the attention of others than statisticians and serve to promote the planning of more adequate health services for children and adolescents so that young men and women of future generations may achieve a maximum level of good health."

The paper "More Adequate Provision and Better Integration of Community Facilities" discusses some of the emerging concepts in the public health field that give new hope that we really can get somewhere. Public health workers reading these papers cannot help but be inspired to get at the job and try again.

Letter to the Editor

Excitement in Halifax

The sea was so calm that a sailboat, trying to induce a fleeting breeze to take it for a jaunt, was having no success. An R.C.A.F. shore boat, whizzing by, made it bob up and down like a cork. The water looked peaceful with lovely lights catching each smooth ripple, and the setting sun threw its colours around, to be tossed off by the water in a gay swirl. The blue sky, decorated with white puffy clouds, made a beautiful back-drop and all was peace. Yes, it was all very lovely as we watched the usual activity of a busy harbour — and destruction, if we thought about it at all, seemed very far away and unreal.

A game of cribbage out on deck had been stimulating, even though I confess to having been "skunked", and I was just about to start in anew with optimism when suddenly a deafening noise interrupted the pressure in my ears and made me gulp. The ship shivered and with one leap we were all rushing aft to see what had happened.

A colossal column of smoke, black and curling, was rising into the air about seven miles away as the crow flies, over near Bedford Basin. We watched its ascent, fascinated, and began to speculate about its cause. It could be oil, we thought aloud; it *could* be ammunition, someone opined; and yet, there seemed to be no aftermath — there seemed to be no more smoke — curious — and we all thought about Halifax and its past.

In a little while some scattered explosions could be heard, then more smoke started up. Flashes of fire could be seen from where we were, and soon our public address system announced that Halifax, once more, was the epicentre of blast from an exploding ammunition dump!

Poor Halifax! How many times she has had her face shattered by explosions from one cause or another. There was that dreadful holocaust in 1917 in which a couple of thousand lost their lives. In 1941, too, a ship was blown up in the harbour, without damage it is true, but with a shock to those who remembered the last *debacle*. And then, the downtown section was wrecked and devastated during the V-E Day riots in May, 1945! The awful part of that day's events was the realization that, while the greater part of humanity was celebrating the end of ruin and destruction in Europe, a mob in Halifax was creating ruin and destruction there!

When I arrived in Halifax on July 12, 1945, its streets were still pock-marked from those riots. Some of the windows in the shopping district were still boarded up, and, though the promise of new store-fronts pleased many of the natives, the merchants who had to bear the expense of repairs were still trying to procure plate glass and workmen to instal it. And — today all is chaos again! As I walked through the streets the whole town looked pathetic and dispirited. Windows newly put in were just shattered heaps on the sidewalks; upper floors of buildings had large gaping holes where there had been windows; and St. Matthew's Church, where we had attended service just a few days before, had a large arched hole where a stained glass window had adorned the tower over lovely oak doors. Demolition and destruction were everywhere, while at street corners serious people gathered in clusters to relate their reactions to the past frightening and sleepless night, and to speculate with apprehension on the immediate future, which was enough to terrify anyone.

All night long, the intermittent explosions punctuated the normal noises of city life, and all night long, flashes of light and shooting particles lit up the blackness. Eerily, the outlines of buildings were silhouetted against the flares at irregular intervals, and fearfully we awaited news of how much destruction was being wrought.

You see, we were on duty on the hospital ship, *Letitia*, which was tied up in the harbour after returning from Europe with war casualties a few days before. The whole staff was ordered to "stand by" for eventualities, and we hastily made up beds and opened wards for the receipt of possible patients from the danger area. Most of the night we paced up and down the ship's passageways fearful of every succeeding blast. The two four o'clock blasts made the ship

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rock and shudder, and we wondered if the main "dump" was in any danger of exploding.

By breakfast time we were still fearful and anxious because, according to the newspapers, the danger was not yet passed, although the explosions had diminished since the early morning blasts — but the largest ammunition dumps were in the path of the heat and flame of the extending fire! The fear was expressed that, if the main dumps went off, the whole town would be decimated!

In the meantime, Halifax Military Hospital, quite close to the danger area, had evacuated most of its patients to make room for more that might come. We had taken fifty-eight of these patients on board and were keeping them until the danger was passed; some were victims of the blast but none seriously hurt. To everyone's unbounded relief the danger was declared to be over about mid-afternoon and the city learned with thankfulness that the main dumps had been successfully flooded.

Those unfortunates, who had been evacuated from the immediate vicinity and who had spent twenty-four hours in open parks and public buildings at a safe distance, started their trek back to their homes. They were all tired, especially the older ones, but they were all good-natured, and many a sally was heard amongst different groups as each tried to bolster up the courage of the other. Volunteer groups appeared from nowhere and ministered to the hundreds. Coffee and sandwiches arrived from all directions and neighbouring communities wired to see what they could do to help. It takes a disaster to show up the best in people. However, all is now quiet again — the city has returned to its normal routine. Stores are open for business, even though their fronts are just gaping holes again. Deliveries are being made and an unmistakable air of relief is abroad as people start to count the cost and prepare for whatever the future holds. The air is clear of smoke, the sky is very blue and it even has some white puffy clouds floating around. The sea is again tossing around its colours as we prepare our hospital ship for another voyage for more Canadian war casualties.

—Nursing Sister B. Jenkins.

Victorian Order of Nurses for Canada

Victorian Order scholarships for the purpose of assisting nurses to take post-graduate study in public health nursing have been awarded to the following nurses who are attending the universities indicated:

University of Alberta: Eleanor Jamieson Hilda Law, Ruth Sheppard.

University of British Columbia: Margaret Forry.

University of Manitoba: Irene Halford, Mrs. Jean Howey, Merle Pringle.

McGill University: Ruth Franklin, Margaret Joyce, Margaret Lownds, Christene MacKaracher, Patricia Merriman, Mrs. Bettie Norris, Mrs. Marjorie Salter, Marion Shore, Evelyn Weaver.

University of Toronto: Phyllis Beardsall, Evelyn Boyd, Mary Clancy, Violet Dick, Marian Doherty, Bernice Giles, Helen Gowdy, Frances Hewgill, Ethel Irwin, Ruth Kirkpatrick, Janet Laing, Olwin McInnes, Marjorie McIntosh, Elizabeth McKenna, Edith McKerlie, Violet Mabee, Velma Martin, Adella Matusaitis, Edith Rose, Eva Secord, Hilda Tackaberry, Edna Valiquette, Lorna Warman, Mrs. Gwen Watt, Mary Whiteside.

University of Western Ontario: Betty Brown, Claire Hicks, Doris Kirkwood, Mary Leyden, Barbara Shook, Helen Thompson, Annie Wade, Elsie White.

The following nurses have been appointed to the Toronto staff:

Doris M. Campbell has returned to the staff on the completion of her post-graduate studies in public health nursing at the University of Toronto; *Margaret Anderson* (Wellesley Hospital, Toronto); *Mary Comartin* (St. Michael's Hospital); *Iva D. Curry* (St. Joseph's Hospital, Toronto); *Lois Gorman* (Hospital for Sick Children, Toronto); *Margaret Janzen* (Women's College Hospital, Toronto); *Elizabeth Kerswill* (Toronto General Hospital); *Ruth*

Watson (Women's College Hospital, Toronto); *Madeline Weber* (Toronto Western Hospital); *Phyllis M. Keep* (Grey Nuns' Hospital, Regina); *Mary I. Morrell* (Toronto General Hospital); *Grace Pilger* (Women's College Hospital, Toronto); *Florence Sinclair* (Toronto Western Hospital). These nurses are all graduates of the certificate course in public heatlh nursing at the University of Toronto.

The following nurses have been appointed to the Montreal staff:

Laure Bergeron (Ottawa General Hospital); *Reta Coady* (Charlottetown Hospital); *Beryle Hawley* has been re-appointed to the staff on the completion of her post-graduate studies in public health nursing. These nurses are graduates of the certificate course in public health nursing at McGill University.

The following nurses have been appointed to the Vancouver staff:

Mrs. Ennis Hayward (Vancouver General Hospital; B.A.Sc., University of B.C.); *Mrs. Kathleen Hyslop* (Vancouver General Hospital) and *Liana Marano* (Edmonton General Hospital), both graduates of the certificate course in public health nursing, University of B.C.

Margaret A. Campbell (St. Joseph's Hospital, Victoria, and course in public health nursing, University of B.C.) and *Verna Campbell* (Brantford General Hospital and course in public health nursing, University of Toronto) have been appointed to the York Township staff.

M. Hope Gauld (University Hospital, Edmonton; B.Sc., University of Alberta) has been appointed to the Victoria staff.

Julia Meyer, having completed the course in public health nursing at the University of Western Ontario, has returned to the Order and has been appointed nurse-in-charge of the Whitby Branch.

Margaret McNabb (Victoria Hospital, London; B.Sc.N., University of Western Ontario) has returned to the Order and has been appointed to the Hamilton staff.

Mabel Russell (Homoeopathic Hospital, Montreal, and course in public health nursing, McGill University) has been appointed to the North Vancouver staff.

Carol E. Sellhorn (University Hospital,

Edmonton; B.Sc., University of Alberta) has been appointed to the Edmonton staff.

Marion Schwanbeck (St. Michael's Hospital, Toronto, and course in public health nursing, University of Toronto) has been appointed to the Saskatoon staff.

Helen Voss, having completed the course in public health nursing, University of B.C., has returned to the Order and has been appointed to the Sarnia staff.

Marion Werry (Brantfdro General Hospital and course in public health nursing, University of Toronto) has been appointed to the Belleville staff.

G. Vivian Adair has been transferred from the Ottawa staff to take charge of the Belleville Branch. *Olive Bell* has been transferred from the Sydney staff to take charge of the Brockville Branch. *Grace Versey* has been transferred from the Toronto staff to take charge of the London Branch. *Ethel Gordon* has been transferred from the Belleville Branch to the position of assistant superintendent of the Ottawa Branch. *Lucille Beaudet* has been transferred from the Digby to the Sherbrooke staff. *Mrs. Catherine Kelly* has been transferred from the London to the Vancouver staff. *Therese Laframboise* has been transferred from the Border Cities to the Montreal staff. *Marion Wismer* has been transferred from the Montreal to the Vancouver staff. *Margaret Allen* has been transferred from the Dartmouth to the Saint John staff.

Mrs. Margaret Houlgrave, Ruth Abell, Mrs. Frances Dalziel and *Agnes Collver* have resigned from the Toronto staff, the latter having accepted a position with the Toronto Department of Health. *Ada Benvie* has resigned as nurse-in-charge of the Wolfville Branch and is retiring from active nursing. *Dorothy Crozier* has resigned as nurse-in-charge of the St. Thomas Branch to take up other work. *Mary Mercer* and *Mrs. Kay Jenkins* have resigned from the Montreal staff. *Lillian Fryers* has resigned from the Winnipeg staff to take up other work. *Lora Furhop* has resigned from the Surrey staff to accept a position with the Provincial Department of Health, Alberta. *Geraldine Garnett* has resigned as nurse-in-charge of the Brockville Branch to be mar-

ried. *Susie Jones* has resigned from the Victoria staff and has accepted a position with the Provincial Department of Health, B.C. *Elizabeth Patterson* has resigned as nurse-in-charge of the Whitby Branch and is retiring from active nursing. *Verona Smith* has resigned from the Victoria staff and has accepted a position as health teacher in St. Joseph's Hospital Training School, Toronto. *Anna Whiston* has resigned as nurse-in-charge of the Bridgewater Branch.

New Brunswick

Public Health Nursing Service

Ray McKenzie (Montreal General Hospital and McGill University public health course) has been appointed to Carleton county.

Corinne Pichette (St. François d'Assise Hospital, Quebec City, and University of Montreal public health course) has been appointed to Madawaska County.

Dorothy Titus (Saint John General Hospital and McGill University public health course) has been appointed to York County replacing *Cecilia Pope* who has resigned.

Katherine MacLaggan (Royal Victoria Hospital and McGill University public health course) has been appointed to organize the work in Westmorland County.

Ontario

Public Health Nursing Service

Marjorie Rutherford (Victoria Hospital, London, and University of Western Ontario public health course) recently returned from overseas service with the R.C.A.M.C., and has accepted the appointment of public health nursing supervisor of the Elgin-St. Thomas Health Unit.

Marion Thompson (Toronto General Hospital and University of Toronto certificate course in public health nursing and lecture course in administration and supervision)

and *Elizabeth Gillespie* (Hospital for Sick Children, Toronto, and University of Toronto public health course, and McGill University course in supervision in public health nursing) have been appointed supervisors with the Windsor Department of Health which has recently taken over the School Nursing Service and organized a generalized program.

Mrs. Dorothy (Armstrong) Shapter (Hamilton General Hospital and University of Western Ontario public health course) has accepted an appointment on the staff of the Elgin-St. Thomas Health Unit.

Kathlyn B. MacDonell (University of Ottawa School of Nursing and McGill University public health course) has accepted a position with the York Township Board of Health.

Ann Sumka (St. Boniface Hospital and McGill University public health course) has accepted an appointment with the East York Dept. of Health.

Goldie Duncanson (St. Joseph's Hospital, London, and University of Western Ontario public health course) has accepted an appointment with the Chatham Board of Health.

Alli Huhta (St. Mary's Hospital, Timmins, and University of Toronto public health course), *Olive Smith* (Toronto General Hospital and University of Toronto public health course), and *Ina Vokes* (St. Joseph's Hospital, Hamilton, and University of Western Ontario public health course) have accepted appointments with the St. Catharines-Lincoln Health Unit.

Elizabeth Ryan (St. Joseph's Hospital, London, and University of Western Ontario public health course) has accepted an appointment with the Sarnia Board of Health.

Florence Stewart (Toronto General Hospital and University of Toronto public health course) has accepted an appointment with the Guelph Board of Health.

M.L.I.C. Nursing Service

Rita Chamberland (St. Sacrement Hospital, Quebec City), *Mariette Leger* (Notre Dame Hospital, Montreal), and *Lucinda Le-*

may (Notre Dame Hospital, Montreal, and University of Montreal public health course) have been appointed to the Metropolitan nursing staff, Montreal.

Madelcine Bulteau (Ste. Jeanne d'Arc Hospital, Montreal, and University of Montreal public health nursing course) was transferred recently from Montreal to take charge of the Service in Joliette. *Alma Morache* (Notre Dame Hospital, Montreal and public health course, McGill School for Graduate Nurses), who has been in charge of the Service in Niagara Falls, was transferred recently to Montreal.

Jeanne d'Arc Hamel (St. Sacrement Hospital, Quebec City) has been granted a Company scholarship, and leave of absence from the Quebec City nursing staff, to take the public health course at the University of Montreal. *Simonne Rouillard* (St. Luc Hospital, Montreal, and University of Montreal public health course) will take leave of absence from the Montreal staff to take up further nursing studies at McGill University with a Company scholarship.

Jeannette Coulombe (St. Sacrement Hospital, Quebec City), who was on the Quebec city nursing staff, recently resigned from the Company's service. *Ina Dickie* (Hamilton General Hospital and University of Western Ontario public health course), who was in charge of the nursing service in Sudbury, has resigned to take up further nursing studies.

NEWS NOTES

ALBERTA

EDMONTON:

The Royal Alexandra Hospital Alumnae Association recently held its opening meeting of the season, with the president, V. Chapman, in the chair. Plans were completed for a bazaar to be held in November, the proceeds to go towards the scholarship and sick benefit funds. The meeting took the form of a shower of articles for the bazaar and many beautiful gifts were received. This year the annual scholarship has been awarded to Jean MacKie of the Class of 1943 who is taking a post-graduate course in administration at the University of Toronto School of Nursing.

The first regular meeting of the University of Alberta Hospital Alumnae Association was held recently when plans for the future were discussed. These include a dance, an open forum under the direction of the public health section, a student nurses' night,

a supper meeting, and a night when scientific medical films will be shown in co-operation with the Association of Scientific Workers.

Four new committees have been set up as follows: (1) A public health section under Helen McArthur; (2) a hospital and general nursing section under Peggy Wylde; (3) liaison with the Alberta Association of Registered Nurses, D. Guild, P. Holowaychuk, Mrs. J. Sleath; (4) a committee to study legislation in Canada and Alberta which affects the status and working conditions of nurses under Mmes W. Hahn and R. Milner.

Elizabeth Rogers addressed the members on the work of the A.A.R.N. of which she is executive secretary. Following other provinces, Alberta is to set up a Nurse Placement Bureau. Miss Rogers explained the salary schedule that the association has drawn up and is at present negotiating with representatives of the Alberta Hospital Association.

The alumnae executive for the 1945-46 term follows: president, Mrs. J. Morrison; vice-president, Mrs. R. Sellhorn; recording secretary, B. Armitage; corresponding secretary, R. Fadum; treasurer, V. Clark; social committee, E. Markstead, E. Eckmeyer.

BRITISH COLUMBIA

Cowichan District:

The annual meeting of the Chapter of the R.N.A. of Cowichan District was held during the summer at King's Daughters Hospital, Duncan, when the following officers were elected: president, Mrs. H. Russell; vice-president, Mrs. T. Skillicorn; secretary-treasurer, K. M. Struthers; social convener, M. Wolfe; press representative, I. Howard.

It was suggested that, for the coming year, every second meeting be devoted to discussions on nursing problems, the alternate meetings to be of a social nature to which all graduate nurses in the District be invited.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

District 4

St. Catharines:

A well attended regular meeting of the Niagara Peninsula Chapter, District 4,

R.N.A.O., was held recently at the Leonard Nurses Home. The chairman, Stella Murray, welcomed those present and minutes of the last meeting were read by Mrs. J. D. Lynn, secretary-treasurer. Interesting reports were heard as follows: Investigation on Job Instruction Methods, by Helen Brown; Hospital Schools of Nursing, by Norma Newman; General Nursing Section, by Catharine O'Farrell.

Lieut. Eleanor Rider, nursing sister attached to the American Army and a St. Catharines General Hospital graduate, was welcomed at this meeting. The association was also pleased to have with them Jean Scrimgeour who, until recently, was a nursing sister with the R.C.A.M.C. N/S Scrimgeour was one of the survivors who did such a gallant piece of rescue work when the ill-fated *Santa Helena* was torpedoed and sunk in the Mediterranean in November, 1943. Public health nurses from the Lincoln County Health Unit and the Welland-Crowland Health Unit were also welcomed.

Through the courtesy of the Lincoln County Medical Association the members heard an informative address on Penicillin and Streptomycin which was given by Dr. Philip Greey of the Banting Institute.

WELLAND:

The opening gathering of the Welland Nurses Association took the form of an enjoyable weiner and corn roast at the home of Mrs. J. Reuter. A short business meeting was held and $100 was donated for purchasing heavy coats and capes for nurses in the Netherlands.

At the October meeting Mrs. C. Hill, the president, was in charge. Plans were made to hold a card party. Ten dollars was donated to the Salvation Army and a contribution was made to the Welland Children's Aid Society. Anne Jack, who recently became associated with the Welland-Crowland Health Unit, told of her experiences with No. 15 Canadian General Hospital in Africa. Mrs. E. Hanna thanked the speaker. A social hour followed.

QUEBEC

MONTREAL:

Royal Victoria Hospital:

E. Mansfield is in charge of the private ward of the newly opened military annex of the Montreal Neurological Institute. V. Young is in charge of the public ward. H. Lamont is now in the training school office as supervisor of the medical wards. L. Ellis has charge of the urological department. Major Christine Crawford, R.R.C., is now matron of the hospital ship *Letitia* en route to Hong Kong. Mrs. M. (Stacey) McQueen

recently resigned her position as assistant head nurse of the 1st floor east, Allan Memorial Institute.

The following nurses have registered at the McGill School for Graduate Nurses: Julia Cookson, Florence Gass, Edith Green, teaching and supervision certificate course; Violet Boone and the recently discharged nursing sisters D. Carter, G. Hopkins, I. MacKay, E. Rowell, public health certificate course; N/S Sheila Mingie, public health degree course; Jean McGregor, Jean Thirlaway, teaching and supervision degree course. N/S Wilhelmina Bell and Frances Simpson are taking the teaching and supervision course at the University of Toronto School of Nursing.

Mrs. C. (King) Bell was a recent visitor at the hospital. Mrs. A. (Pickard) Crawford has returned with her family to Beirut, Syria, after spending several war years at her former home in Sackville, N.B.

SASKATCHEWAN

Moose Jaw:

Naomi Webber (Regina General Hospital and University of Saskatchewan School of Nursing) has been appointed instructress at the Providence Hospital. Florence Kuntz is leaving the staff of this hospital shortly for the east.

Prince Albert:

Rev. Sr. Symphorosa, directress of the Holy Family Nursing School for the past eighteen years, has been transferred to Vancouver. An entertainment was held in her honour prior to her departure. Rev. Sr. Irene and Sr. Agnes Patricia have returned from Eastern Canada where they attended summer school and classes at Loyola College, Montreal. N/S Ruth (Nordstrom) Blight has recently returned from overseas.

The Victoria Hospital Nursing School recently held their graduation exercises in the United Church.

Regina:

F. Philo has been appointed instructress of nurses and Noreen Mullen is teaching practical nursing at the Grey Nuns' Hospital. A class of fifty-three students has just been enrolled, Mrs. Ann Hernoi, Mrs. E. L. Lach and Miss Bolstad have been appointed to the maternity department. Mary Karabis has accepted a position at St. Peter's Hospital, Melville. Mrs. A. Dwight has resigned to make her home in B. C.

Yorkton:

Alice Mills, recently on the staff of the Yorkton General Hospital, has accepted a position at the hospital in Dawson City, Yukon. N/S Betty Langstaff has returned to Canada after spending four years with the South African Nursing Service. N/S Langstaff has served in South Africa, Egypt and Italy.

WANTED

Applications are invited for the following positions in an up-to-date hospital:

Ward Supervisor for 15-bed private wing.

Ward Supervisor for 9-bed private wing. Knowledge of X-ray work or willing to learn same to relieve X-ray technician.

Floor Supervisor for **Night Duty** in a 34-bed unit. Three student nurses on duty.

Eight-hour day or night; staggered hours; six-day week. Salary $85 less tax, with full maintenance. Apply to:

General & Marine Hospital, Collingwood, Georgian Bay, Ont.

WANTED

Applications are invited for the position of an **Assistant Superintendent of Nurses** in a 650-bed hospital. A **Second Assistant Superintendent of Nurses** (new position) is also required, to be primarily responsible for Ex-Servicemen's Pavilion (250 beds), with some administration duties in main building and School of Nursing.

Both positions available **immediately.** Cost of railway ticket to Edmonton will be refunded after six months service. Apply, stating qualifications and experience, to:

Superintendent of Nurses, University Hospital, Edmonton, Alta.

WANTED

A competent nurse is required for the position of **Operating Room Supervisor.** Apply, with references, stating experience and salary required to:

Superintendent, Prince County Hospital, Summerside, P. E. I.

WANTED

Registered Nurses are required for the **Huntingdon County Hospital.** The salary is $80 per month with room and board provided. For further particulars apply to:

Dr. H. R. Clouston, Superintendent, Huntingdon County Hospital, Huntingdon, P. Q.

WANTED

General Duty Nurses are required for a 350-bed **Tuberculosis Hospital.** Forty-eight and a half hour week, with one full day off. The salary is $100. per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

A class room **Instructress** for a 120-bed hospital. Apply stating qualifications, experience and salary expected to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

Applications are invited for the position of permanent **Night Supervisor** at a salary of $95 per month. **Floor duty nurses** are also required at a salary of $85 per month. Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for **General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. **Salary:** $95 per month living out, plus $19.92 Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital
Vancouver, B. C.

WANTED

A **Dietitian** and a **Supervisor** for a **Tuberculosis Annex** are required **immediately** for the **Highland View Hospital, Amherst.** Apply, stating qualifications, to:

Business Manager, Highland View Hospital, Amherst, N. S.

WANTED

An experienced **Supervisor for Private Patients Floor** is required for a 153-bed hospital. **General Duty nurses** are also needed. Apply in care of:

Box 9, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

Graduate Nurses are required for **General Duty** in a well-equipped 35-bed hospital. 8-hour day and 6-day week. The salary is $22 (less income tax) per week with full maintenance. Apply to:

Superintendent of Nurses, Anson General Hospital, Iroquois Falls, Ont.

WANTED

A **Dietitian** is required fro the **Cornwall General Hospital.** Salary, $130 per month with full maintenance. Apply to:

Assist. Superintendent, Cornwall General Hospital, Cornwall, Ont.

WANTED

Charge nurse is required for **Babies' Cottage** (birth to 5 yrs.) Capacity 25 cots and bassinettes—average 18. Apply, stating qualifications, age, etc. to:

Superintendent of Nurses, Toronto Hospital for Tuberculosis, Weston, Ont.

WANTED

A Registered Nurse is required as **Night Supervisor** for a 75-bed hospital. The salary is $100 per month with full maintenance. A Registered Nurse is also required as **Assistant Supervisor.** The salary is $90 per month with full maintenance. For particulars apply to:

Superintendent, Grace Hospital, Ottawa, Ont.

Official Directory

THE CANADIAN NURSES ASSOCIATION

1411 Crescent St., Montreal 25, P. Q.

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Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. M. Irene, Charlottetown Hospital; (3) Miss S. Newson, Junior Red Cross, Charlottetown; (4) Miss M. Lannigan, Charlottetown Hospital.

Quebec: Miss E. Flanagan, 3501 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Mathews St., Montreal 25; (3) Miss A. Girard, l'Ecole d'infirmières hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 1230 Bishop St., Montreal 25.

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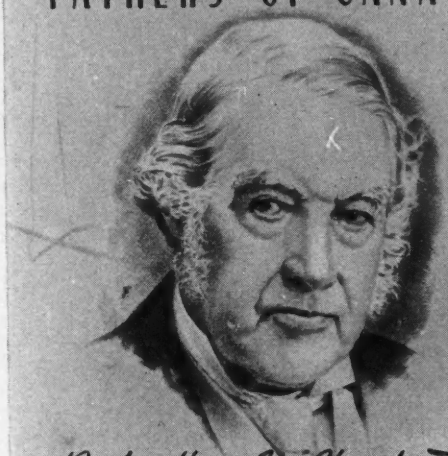
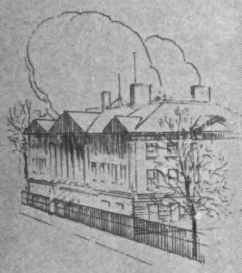




Right Hon. Sir Charles Tupper

BART., C.B., G.C.M.G., M.D., LL.D.

PHYSICIAN AND STATESMAN (1821-1915)

COURAGE, boundless optimism and breadth of vision characterized the distinguished career of Sir Charles Tupper. Despite the demands of public office, he maintained an active interest in all matters concerning the medical profession.

Tupper was born at Amherst, N.S., July 2nd, 1821. He studied medicine at Edinburgh University where he received the degrees of M.D. and L.R.C.S. in 1843. Of medium height, erect, and vigorous, Charles Tupper had an abundance of nervous energy which contributed to alertness and ceaseless mental activity. His manner was hearty and genial and he had a broad grasp of most topics.

In 1862 Tupper was appointed a Governor of Dalhousie College, Halifax, where he initiated a medical course which reached full fruition in 1870. It was largely due to his persistence that in 1867 the Victoria General Hospital began its existence in Halifax as a provincial and city institution. When the Canadian Medical Association was formed in 1867 he was elected President.

The year 1855 marked the beginning of Tupper's political career. It is said that history will record the four years of his administration as Premier of the Province of Nova Scotia as the greatest era in Tupper's life—an era in which he achieved the most striking personal success. Against strong opposition he established a system of free schools for Nova Scotia.

Tupper was the apostle of Confederation and played an important part in the passage of the British North America Act. He actively supported efforts to establish a Federal Department of Health which, after much missionary work, became a reality in 1919.

He was made a Baronet in 1888. For two different periods he held the position of High Commissioner for the Dominion in London and in 1896, was made Prime Minister of Canada.

Sir Charles died at "The Mount", Bexley Heath, England, on October 30th, 1915. The record of his life is a challenge to the medical profession and inspires William R. Warner & Company in their policy of Therapeutic Exactness . . . Pharmaceutical Excellence.

Reader's Guide

The arguments for early immunization against whooping-cough, presented so ably by **Dr. Lawrence E. Ranta**, will serve to reinforce the programs conducted by public health nurses everywhere. The high percentage of the deaths from this disease which occur among infants under one year can be markedly reduced if adequate protection is secured at an early age. The case which he presents for scarlet fever immunization should help to combat the widespread reluctance to accept this means of ensuring even the more limited security which is afforded. Dr. Ranta is assistant director of the Connaught Laboratories (Western Division) and assistant professor in the Department of Bacteriology and Preventive Medicine at the University of British Columbia.

Dr. S. A. MacDonald, of Montreal, has given us an interesting description of the various types of paralyzed bladder and a detailed account of one particular patient. Using this same case as an excellent example, **Clara R. Aitkenhead**, chief instructress at the Homoeopathic Hospital, Montreal, has shown how teaching opportunities may be turned to good account.

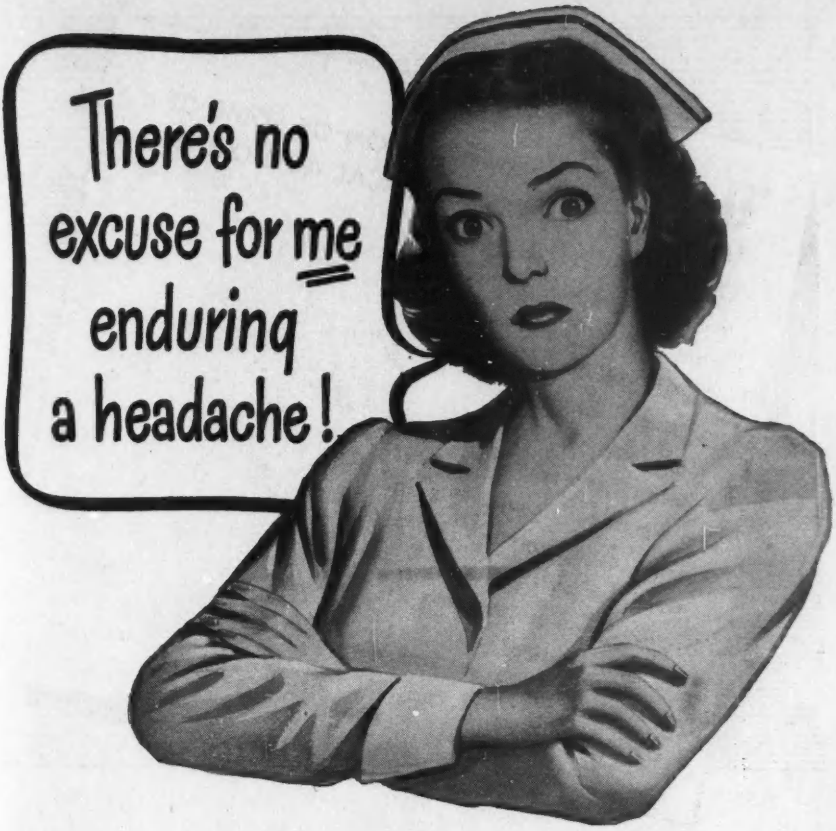
Under the auspices of the Alberta Association of Registered Nurses and the School of Nursing of the University of Alberta, a course in hospital administration was provided. **W. J. Coleman**, a representative of a hospital supply company, presented the exceedingly valuable suggestions for the preservation of hospital equipment to this group. The many useful points which he has included will, we hope, help the harassed hospital personnel to make this last until new materials are again available.

In the November issue of the *Journal* we presented the first instalment of **Edith Buchanan's** interesting and timely story of nursing conditions in India. This month we conclude her account of the efforts that are being made to raise the standard of training being provided and to make a greater volume of nursing care available to India's teeming millions. Miss Buchanan is a graduate of the Royal Victoria Hospital, Montreal.

Dorothy L. Ward is a graduate of the Homoeopathic Hospital, Montreal. At present, she is taking her course in teaching and supervision at the McGill School for Graduate Nurses, preparatory to returning to her alma mater as a clinical instructor.

Margaret O. Cogswell, recently appointed as director of the newly organized Nurse Placement Bureau in Alberta, sets a pattern, which Instructors' Groups in every community might well copy, in her description of the monthly gatherings held in Edmonton. Similarly, **Hester Lusted** shows a way in which public health nurses may expand their knowledge and understanding of the community in which they work and its possible resources. Miss Lusted is a public health nurse in Regina, Sask. The thoughtful presentation of the possibilities to be found in a small community hospital by **Jean White** should be an eye-opener to many nurses who have never lived anywhere but in the city and whose professional experience has all been in large hospitals.

The four small tots depicted on our cover did not wait in vain for a visit from good St. Nicholas. The empty fireplace permitted the jovial gentleman to arrive without even scorching his whiskers. It is our sincere wish that this Christmas will bring the heart's desire to all of our readers, with a full measure of happiness to carry over into the New Year. **Merry Christmas!**



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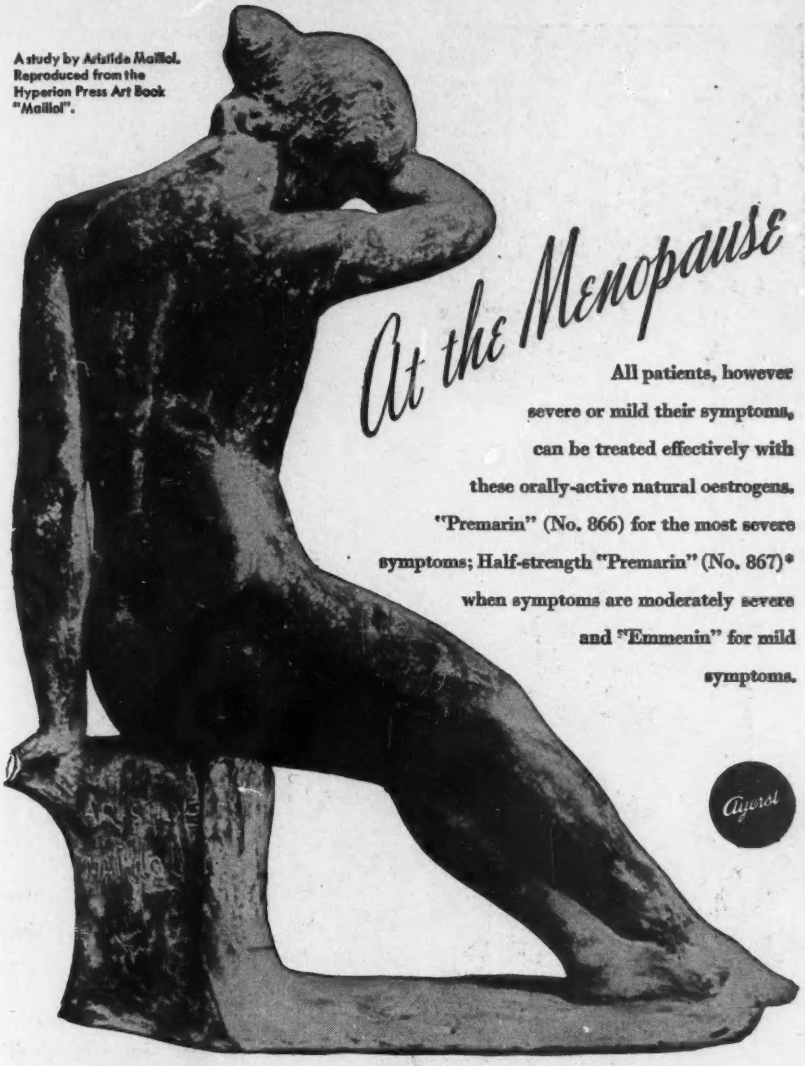

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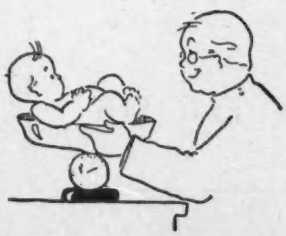

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